Assignment Cover Sheet

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Contents:

Abstract 5

Chapter One: Introduction, Background and Literature Review 7

- Introduction and Background
- Literature Search
- Workplace Culture in O&G
- Bullying, Incivility and Undermining
- Educational Perspectives
- Chapter Summary

Chapter Two: Methodology 21

- Study Design
- Research Aims and Questions
- Participant Selection and Sampling Strategy
- Data Collection
- Reflexivity and Researcher Positioning
- Data Analysis
- Trustworthiness and Rigour
- Ethical Considerations
- Methodological Limitations
- Summary of Methodology

Chapter Three: Findings …….. 29

- Introduction
- Organisational Culture and Structural Influences
- Interpersonal Dynamics and Equity
- Individual Responses and Psychological Experiences
- Consequences for Professional Practice and Patient Care
- Chapter Summary

Chapter Four: Discussion *43*

- Workplace Culture and Learning
- Psychological Safety
- Hidden Curriculum
- Communities of Practice
- Labour Ward Handover
- Strengths and Limitations
- Answering the Research Questions
- Future Research

Chapter Five: Conclusion *61*

- Summary of the Study

- Answering the Research Question
- Contribution to Medical Education
- Implications for Educational Practice and Organisational Development
- Recommendations for Future Research
- Final Conclusion

References *69*

Appendix *77*

Appendix A – Booth 3W Search Tool

Appendix B– Data Extraction Table

Appendix C – Participant Information Sheet

Appendix D – Participant Consent Form

Appendix E – Research Questions

Appendix F – Ethical Approval

Appendix G – Recruitment Email

Abstract:

Workplace culture is increasingly recognised as an important influence on learning within postgraduate medical education. In Obstetrics and Gynaecology (O&G), concerns have been raised regarding the persistence of bullying, undermining, and incivility within training environments. While previous research has highlighted the prevalence of these behaviours and their potential consequences for residents, less attention has been paid to how residents themselves understand and navigate these experiences. As workplace culture forms part of the hidden curriculum, exploring resident perspectives may offer insights into how professional norms are learned, reinforced, and challenged within clinical practice.

The aim of this study was to explore O&G residents' experiences of workplace culture and workplace bullying within a United Kingdom (UK) National Health Service (NHS) training environment. A qualitative methodology was adopted, using semi-structured interviews with eight current or former O&G residents. Interviews were conducted either in person or via Microsoft Teams, transcribed verbatim, and analysed using Braun and Clarke's reflexive thematic analysis. NVivo software was used to support data organisation and coding throughout the analytical process.

Four overarching themes were developed from the data. Participants described O&G as a specialty shaped by a longstanding reputation for poor workplace culture, often linked to hierarchy and clinical pressure. Accounts of bullying and incivility ranged from overt criticism to more subtle forms of exclusion and undermining. However, participants frequently questioned where the boundary lay between unacceptable behaviour and communication shaped by the demands of a busy clinical environment. Labour ward handover emerged as a particularly significant setting within participants' narratives, with many describing feelings of apprehension, scrutiny, and fear of public criticism. Negative workplace interactions shaped how residents participated in the workplace, with some describing reduced confidence and a reluctance to engage in certain learning experiences. At the same time, participants highlighted the importance of supportive supervisors and positive role models in shaping more favourable training environments.

The findings suggest that residents experiences of workplace culture are influenced not only by individual interactions but also by wider organisational and educational contexts. Participants' accounts reveal the complexity of interpreting bullying within environments

characterised by high workload and responsibility. The study highlights the value of training environments in which residents can engage with learning without feeling vulnerable to judgement or ridicule. In doing so, it contributes to current discussions surrounding workplace culture in postgraduate medical education and offers a greater understanding of how workplace culture is experienced by O&G residents.

Chapter One: Introduction, Background and Literature Review

Introduction and Background:

Workplace culture has become an increasingly important focus within postgraduate medical education, reflecting growing recognition of its influence on resident learning and patient safety. Organisational culture has been conceptualised as the shared values, beliefs and assumptions that influence behaviour within an organisation (Schein, 2010). Although originally developed within educational settings, the concept of the hidden curriculum has subsequently been applied to healthcare to explain how learners acquire implicit values, behaviours and professional norms through everyday workplace experiences; alongside formal training, thereby shaping professional identity formation (Hafferty, 1998).

The researcher's interest in this topic stems from personal clinical experience in maternity services, where they have witnessed the profound influence of workplace culture on learning and well-being. They have observed how supportive clinical environments foster confidence, collaboration, and high-quality patient care, while negative workplace interactions can have lasting effects on individuals and teams. These experiences prompted the researcher to explore how obstetrics and gynaecology residents experience workplace bullying; not only to understand its impact on those affected but also to identify opportunities to promote safer learning environments and improve staff experience and patient outcomes.

Research interest in workplace culture within O&G has increased over the past decade, with authors increasingly examining bullying, undermining and incivility as features of training environments (MacDougall et al., 2013; Cresswell et al., 2015; Gaillard et al., 2025). Although these terms are often used interchangeably, they represent distinct constructs. Bullying is commonly defined as repeated, persistent negative behaviours directed towards an individual that involve a perceived power imbalance and may undermine professional competence or personal wellbeing (Menabo et al., 2025). Undermining refers to behaviours that erode confidence, professional standing, or authority, often through subtle or indirect actions such as exclusion, humiliation, or persistent criticism (Fayzullaev & Shin, 2024). Incivility is generally considered a lower-intensity form of disrespectful behaviour, including dismissiveness or disregard for professional courtesy. It may not meet the threshold for bullying but can contribute to a hostile work environment over time (Andersson & Pearson, 1999). O&G is particularly vulnerable to cultural challenges due to its high-acuity clinical

environment, multidisciplinary nature, hierarchical training structure and substantial litigation risk.

Therefore, this chapter aims to critically review the existing literature on workplace culture in O&G training. It aims to synthesise the evidence relating to hierarchy and power dynamics and the impact of workplace culture on O&G resident learning. In doing so, it highlights the limitations of the current evidence base and establishes the rationale for a qualitative exploration of residents' experiences of workplace culture throughout O&G training. To critically evaluate and synthesise available evidence, a structured and transparent approach to relevant literature was required. Therefore, the following section will outline the literature search strategy used to identify multiple studies exploring workplace bullying and broader cultural issues within O&G residency.

Literature Search:

Initially, two electronic databases were identified and searched: SOLO and Scopus. SOLO was utilised as an initial exploratory database due to its broad access to multidisciplinary academic literature, including medical education and health science research. Scopus was then selected because of its wide coverage of peer-reviewed journals. Scopus has been recognised as one of the largest databases for health science literature and is frequently used within medical education research due to its comprehensive indexing and advanced search functionality (Falagas et al., 2008).

Following this, search terms were generated using the Booth (2016) 3W Tool to develop comprehensive and relevant keyword combinations [Appendix 1]. Three searches were subsequently undertaken: two within the SOLO database using refined search strategies and one within Scopus. This approach reflected recommendations that qualitative literature searching should prioritise relevance and conceptual richness over excessive duplication across databases (Booth, 2016). Although including additional databases may yield more search results, the benefits become progressively limited once several major databases have been searched, especially in the context of small postgraduate research projects (Bramer et al., 2017).

Searches 1 & 2 used the following phrases & Boolean terms for consistency across both databases:

- “obstetric and gynaecology” OR “O&G” OR “OBGYN” AND
- “trainees” OR “residents” OR “doctors” AND
- “experiences” OR “lived experiences” AND
- “bullying” OR “workplace bullying” OR “horizontal violence” OR “incivility” OR “intimidation”

Following this, one further search (Search 3) was completed on SOLO using a new, different search term combination to expand the literature search to include psychological safety and learning in O&G workplaces.

Search 3 used the following phrases & Boolean terms:

- "hierarchy" OR "workplace culture" OR "organisational culture" AND
- "obstetrics" OR "gynaecology" OR "maternity" AND
- "trainees" OR "residents" OR "doctors"

From the three searches, approximately 75 papers were initially identified, with 53 of those being from the third search alone. Following screening for relevance with the use of an inclusion and exclusion table [Appendix 2] and the removal of duplicates, 18 papers were included. The included studies represented postgraduate O&G training environments in the United Kingdom, the United States and France, alongside one international systematic review. Although the healthcare systems differed, all studies examined workplace culture within postgraduate O&G training, providing a degree of contextual diversity while maintaining relevance to the review question. Inclusion criteria included literature specifically relating to Obstetrics and Gynaecology training environments, workplace bullying, incivility, or related interpersonal behaviours. Papers not specific to O&G or those duplicated across searches were excluded. Of those papers, numerous themes were identified using a data extraction tool [Appendix 3] and are critically evaluated as follows.

The first theme that emerged within this search was ‘workplace culture within O&G’. Workplace culture has become an increasingly prominent concern within research on O&G, with growing evidence suggesting that interpersonal relationships and poor communication are significantly influencing staff wellbeing and patient care. MacDougall et al. (2013) argue that organisational pressures may contribute to environments in which stress becomes normalised. Similarly, Cresswell et al. (2015) echo that bullying and undermining are more

likely to occur in settings characterised by high workload, inadequate supervision and strained professional relationships, which O&G is known for. Although these factors do not directly cause bullying behaviours, they provide important context for understanding workplace culture within O&G.

Workplace culture has important implications for staff wellbeing, with negative workplace experiences contributing to psychological distress and burnout among residents. Evidence from a national study of French obstetrics and gynaecology residents by Gaillard et al. (2025) identified high rates of workplace bullying alongside substantial levels of burnout. The authors reported significant associations between experiences of bullying and emotional exhaustion, suggesting that negative workplace culture and resident wellbeing are closely interconnected. These findings support the notion that organisational pressures may influence not only professional interactions but also the psychological experiences of residents working within the specialty. Importantly, the study demonstrates that concerns regarding workplace culture are not isolated to the United Kingdom but appear to be recognised internationally.

Alongside these workload pressures, hierarchical structures emerge as a prominent feature of O&G culture. Medical training is inherently hierarchical, with residents dependent upon senior colleagues for supervision, assessments, and progression through specialty training. MacDougall et al. (2013) note that bullying frequently occurs in relationships characterised by unequal power where residents feel unable to challenge inappropriate behaviour due to concerns regarding future career progression. Such power differentials are particularly relevant within medical training environments where educational opportunities are often controlled by senior clinicians. Consequently, workplace culture cannot be understood solely as a product of individual behaviour but must also be considered within the broader context of organisational and professional hierarchies.

Issues relating to power and inclusion are also evident within O&G subspecialty workforces. In a survey of women working in gynae-oncology, Hong et al. (2021) identified experiences of workplace bullying, harassment and microaggressions as an ongoing issue. These findings were further explored by Hong et al. (2022), when they examined barriers to the inclusion of women within the surgical workforce. Although Hong et al. (2022) provide valuable insights, their findings derive from gynae-oncology and may not be transferable to broader O&G training populations. Moreover, Gupta et al. (2024), in a systematic review of sexual harassment, abuse and discrimination in O&G, identified persistent reports of gender-based

discrimination and harassment across a range of healthcare settings. The review highlights the extent to which workplace culture extends beyond overt bullying behaviours and encompasses broader issues of inclusion, respect, and professional identity. Taken together, these studies suggest that workplace culture within O&G is influenced not only by formal hierarchies but also by wider social and organisational structures that shape interpersonal relationships.

The importance of communication and teamwork is another theme within the literature. Several authors have emphasised the multidisciplinary (MDT) nature of O&G when discussing workplace culture, arguing that effective communication between professional groups is essential for learning and patient safety (Websdale et al., 2018; Nhundu et al., 2019). Consequently, workplace culture has direct implications for team functioning and patient safety. Human factors approaches are being increasingly adopted within maternity care to improve communication and teamwork. The Human Factors Learning in Obstetrics (HALO) programme described by Websdale et al. (2018) emphasises the importance of non-technical skills and communication in supporting safe clinical practice. The development of such programmes reflects growing recognition that technical competence alone is insufficient to ensure safe maternity care. Likewise, Nhundu et al. (2019) argue that resident bullying has the potential to affect patient care through its impact on communication, decision-making and resident confidence. These perspectives shift the discussion away from viewing bullying solely as an occupational wellbeing issue and instead position workplace culture as a matter of educational and patient safety significance.

Further evidence of the importance of interpersonal behaviour is provided by Pierce et al. (2025), who investigated the impact of incivility during simulated obstetric emergencies. Exposure to uncivil behaviour resulted in significant reductions in team morale and overall performance. Notably, the greatest deterioration was observed in measures relating to communication and teamwork. These findings suggest that workplace culture may have consequences extending beyond staff wellbeing and professional satisfaction, potentially influencing the effectiveness of MDT working during high-risk clinical situations. In a specialty where communication failures are frequently identified in investigations of adverse outcomes, such as the Ockenden report (2022), findings are particularly relevant.

The second major theme identified within the literature was direct bullying, incivility and undermining within O&G training environments. Although workplace culture provides the

broader context within which professional relationships develop, much of the literature relating to O&G has focused specifically on bullying, incivility, and undermining behaviours (Cresswell et al., 2015; Gaillard et al., 2025; Gupta et al., 2024; MacDougall et al., 2013; Nhundu et al., 2019; Pierce et al., 2025; Websdale et al., 2018).. These concepts are often discussed interchangeably, despite describing a spectrum of behaviours that vary in severity and intent. Collectively, however, they represent behaviours that may negatively affect residents' experiences of work and learning.

Reports of bullying within O&G are well established. MacDougall et al. (2013) describe undermining as a longstanding issue within the specialty and note that O&G has repeatedly featured prominently in national surveys investigating workplace bullying. The authors argue that bullying is often sustained by organisational cultures where inappropriate behaviour becomes normalised, and hierarchical structures discourage challenge. Similarly, Cresswell et al. (2013) reported that workplace harassment remained a significant issue amongst O&G residents, despite increasing awareness of its impact on both individuals and organisations.

Whilst traditional discussions of bullying have often focused on overt hostility, more recent literature has drawn attention to less visible forms of workplace mistreatment. Although microaggressions may appear less severe than overt bullying, their cumulative impact can be substantial. Hong et al. (2021) argue that repeated experiences of exclusion, dismissive comments and questioning of competence may contribute to feelings of marginalisation. The authors suggest that these experiences are often difficult to challenge directly due to their subtle nature, allowing them to persist within workplace cultures.

Questions of inclusion and belonging are further explored by Hong et al. (2022), who examined barriers faced by women entering and progressing in the surgical workforce. Although O&G differs from many surgical specialities in having a predominantly female workforce (GMC 2025), Hong et al. (2022) demonstrate that issues relating to inclusion and access to opportunity persist within subspecialty surgical environments like gynae-oncology. The findings suggest that negative workplace experiences are not always the result of explicit bullying behaviours but may emerge through exclusionary practices and unequal access to support. Such observations are particularly relevant when considering workplace learning environments, where educational opportunities are often dependent upon relationships with senior colleagues.

Several researchers also found that experiences of workplace mistreatment may intersect with broader issues of discrimination. Gupta et al. (2024), in their systematic review of sexual harassment, abuse and discrimination within O&G, identified persistent reports of inappropriate behaviour across multiple healthcare settings. The review highlighted the continued presence of gender-based discrimination and harassment despite increasing organisational awareness. Importantly, the authors note that these behaviours may occur within cultures where reporting is perceived as difficult or unlikely to result in meaningful change. This echoes concerns raised elsewhere within the literature regarding under-reporting of bullying and harassment within medicine.

Another recurring theme throughout the research is the difficulty of distinguishing between robust supervision and inappropriate behaviour. O&G is a specialty in which residents frequently work in stressful situations and receive feedback regarding clinical decision-making. MacDougall et al. (2013) acknowledge that effective supervision may at times require direct challenge; however, they argue that there is a clear distinction between constructive educational feedback and behaviour that humiliates, intimidates, or undermines. Cresswell et al. (2015) similarly highlight the need to differentiate between maintaining professional standards, and behaviours that erode confidence and psychological wellbeing. This distinction is important because perceptions of bullying may be influenced by context, intent, and the quality of the resident–trainer relationship.

The studies therefore indicate that bullying behaviours remain an important concern within O&G. Existing studies demonstrate that these behaviours may take multiple forms, ranging from overt harassment to more subtle experiences of exclusion and microaggression. Despite this, it is crucial to note that much of the current evidence is derived from surveys and prevalence studies, which provide limited insight into how residents interpret and navigate these experiences in everyday clinical settings. Whilst existing literature establishes that bullying occurs, there remains less understanding of how workplace culture shapes these experiences and how residents respond to them within the context of learning and professional development.

The evidence base then highlighted the impact of this phenomenon on residents' professional development. Consequences of bullying, incivility and harassment within healthcare extend beyond the immediate experience of the individual involved. While early discussions of workplace bullying often focused on staff wellbeing and organisational performance, more

recent literature has recognised the influence of workplace culture on professional development, confidence, and career progression.

Furthermore, Gaillard et al. (2025) identified significant associations between workplace bullying and burnout amongst O&G residents. Residents exposed to bullying reported higher levels of emotional exhaustion and depersonalisation, suggesting that negative workplace interactions may contribute to psychological distress. Although burnout is multifactorial, their findings reinforce the importance of workplace culture as a contributor to resident wellbeing.

The impact of bullying on confidence has also emerged as a recurring theme. MacDougall et al. (2013) argue that undermining behaviours can have a profound effect on self-belief and professional identity, particularly when experienced repeatedly over time. MacDougall et al. (2013) suggest that experiences of humiliation, criticism or exclusion may lead residents to question their competence and clinical judgement. Such effects are particularly concerning within postgraduate medical education, where confidence develops through supervised participation in increasingly complex clinical activities. A workplace culture characterised by fear or intimidation may therefore hinder progression from dependent learner to independent practitioner.

Several authors have suggested that the educational consequences of bullying may be less visible than its psychological effects. Learning within O&G relies heavily on experiential opportunities, informal teaching, and workplace interactions. Access to these opportunities may be influenced by relationships with senior colleagues and the wider MDT. Hong et al. (2022) highlight how workplace culture can influence inclusion within professional communities, affecting access to mentorship and career development opportunities. Whilst their work focuses primarily on women within the gynae-oncology surgical workforce, the findings illustrate how workplace environments may either facilitate or restrict professional growth.

The cumulative effect of repeated negative experiences may also influence career intentions. Gaillard et al. (2025) reported concerns regarding retention amongst residents exposed to workplace bullying, while Gupta et al. (2024) identified evidence suggesting that experiences of harassment and discrimination may influence career satisfaction and progression. These findings are particularly relevant given ongoing concerns regarding resident retention in O&G, a specialty that experiences some of the highest attrition rates within UK postgraduate

training programmes (RCOG, 2019). If residents perceive workplace environments as hostile or unsupportive, there is potential for these experiences to contribute to attrition at a time when recruitment and retention remain national priorities.

Alongside career implications, workplace culture may shape how residents engage with learning opportunities. Cresswell et al. (2015) note that bullying and undermining can create environments in which residents become reluctant to seek feedback, ask questions or acknowledge uncertainty. Such behaviours are central to clinical learning, particularly within a specialty where patient presentations are often complex and unpredictable. When residents feel unable to expose gaps in knowledge or seek clarification from senior colleagues, educational opportunities may be lost. This has implications not only for skill acquisition but also for the development of clinical judgement and decision-making.

Significantly, several authors argue that the consequences of bullying are not limited to the individual who is directly involved. Cresswell et al. (2013) argue that residents often feel unable to challenge inappropriate behaviour due to concerns regarding future working relationships or career progression. In such environments, behaviours may persist unchallenged and become embedded within local workplace cultures. This creates a cycle whereby new residents enter environments in which certain behaviours have become accepted as part of everyday clinical practice. The existing literature therefore suggests that bullying and incivility have implications extending beyond immediate workplace discomfort. Experiences of negative workplace behaviour may influence wellbeing, confidence, professional identity, and career development, whilst also shaping engagement with workplace learning. However, the mechanisms through which these effects occur remain poorly understood.

A growing body of healthcare research has examined the relationship between workplace culture and patient safety (West et al., 2020; Nhundu et al., 2019). Whilst bullying and incivility have traditionally been viewed as issues affecting staff wellbeing, emerging evidence suggests that their effects extend to decision-making and workplace learning. This is particularly important in O&G, where clinical practice is heavily dependent on MDT work and escalation of concerns. In such environments, interpersonal behaviours can influence not only how residents feel, but also how they learn and practise.

A recurring conclusion within the literature is that negative workplace behaviours alter communication patterns within clinical teams. Nhundu et al. (2019) argue that bullying affects patient care by influencing how residents interact with colleagues and respond to clinical uncertainty. Participants in their study described situations in which intimidation and hostile behaviour reduced confidence and affected willingness to seek assistance. This is particularly concerning in a specialty such as O&G, where junior doctors are expected to escalate concerns promptly when managing deteriorating patients or obstetric emergencies. The evidence suggests delays in communication may therefore have implications beyond individual educational experiences.

Building on earlier conclusions regarding communication and teamwork, the literature suggests that these interpersonal dynamics may also have implications for patient safety. Obstetric emergencies often require rapid coordination within the MDT, with clinicians working under significant time pressure. Effective communication is therefore essential for maintaining situational awareness and supporting timely decision-making. Recognising this, human factors approaches have increasingly been incorporated into obstetric education. The Human Factors Learning in Obstetrics (HALO) programme described by Websdale et al. (2018) was developed in response to growing recognition that non-technical skills, including communication, leadership, and teamwork, are fundamental components of safe maternity care. The programme reflects a wider shift within healthcare education towards understanding patient safety as a product of team performance rather than individual competence alone.

Evidence from simulation research further demonstrates the influence of personal behaviour on team functioning. Pierce et al. (2025) examined the impact of incivility during the management of simulated postpartum haemorrhage (PPH) and found that exposure to uncivil behaviour significantly reduced overall team performance. The greatest reductions were observed in communication and team morale, suggesting that negative personal interactions disrupt the behaviours required for effective teamworking. Whilst simulation studies cannot fully replicate clinical practice, these findings provide valuable insight into the mechanisms through which workplace culture may influence performance. Notably, deterioration in communication occurred despite participants possessing the necessary clinical knowledge to manage the scenario, indicating that technical competence alone may be insufficient in environments with poor interpersonal tension.

These findings also have important educational implications. Effective workplace learning relies on residents feeling able to ask questions, acknowledge uncertainty and seek support when required. When communication is inhibited by intimidation or fear of criticism, opportunities for learning and escalation may be reduced. Consequently, workplace culture has implications not only for resident development but also for the communication and teamwork processes that underpin safe maternity care.

Taken together, the literature suggests that bullying and incivility have consequences extending beyond individual wellbeing. By influencing communication, confidence, and willingness to seek support, workplace culture may shape both learning experiences and patient care.

The literature identified through the search strategy demonstrates that bullying, incivility, and undermining remain important concerns within O&G training environments. Nevertheless, whilst the reviewed studies provide valuable insight into prevalence, consequences, and organisational/cultural factors, they offer less explanation as to how these experiences influence learning and professional development. As this study is situated within the field of Medical Education, it is important to consider educational perspectives that may help contextualise resident experiences and support interpretation of the findings.

The theories discussed below were not identified through the literature search strategy outlined earlier in this chapter. Instead, they were selected following completion of the review due to their relevance to workplace learning and postgraduate medical education. Their inclusion is intended to provide an educational lens through which the findings of the present study may be understood, rather than to form part of the formal literature review itself.

One concept particularly relevant to workplace culture is psychological safety. Psychological safety refers to an individual's perception that they can ask questions, seek support, admit uncertainty, or raise concerns without fear (Edmondson, 1999). Within clinical education, psychological safety has been associated with learning, teamwork, and speaking-up behaviours. The literature reviewed in this chapter repeatedly highlights concerns regarding communication, escalation, and confidence within O&G environments (Nhundu et al., 2019; Pierce et al., 2025). Psychological safety therefore provides a useful framework for

understanding how workplace interactions may influence residents' willingness to participate actively within learning environments.

A second theoretical perspective relevant to this review is the concept of the hidden curriculum. Originating from educational sociology, the hidden curriculum was developed to explain how schools implicitly transmit social values, norms, and expectations beyond the formal curriculum, thereby reproducing broader societal structures and patterns of behaviour (Bowles & Gintis, 1976). Hafferty (1998) subsequently adapted this concept to medical education, arguing that learners acquire professional values, attitudes, and behaviours through everyday participation in clinical environments in addition to formal teaching. Rather than explaining organisational culture itself, the hidden curriculum provides a lens to understand how professional norms and behaviours are learned and reinforced in healthcare settings. Several studies included in this review suggest that bullying and undermining behaviours may become normalised through these informal learning processes (Cresswell et al., 2015; MacDougall et al., 2013).

Workplace learning theories may also help explain how culture influences educational experiences. Lave and Wenger (1991) propose that learning occurs through participation within communities of practice, whereby newcomers become integrated into a shared professional community by acquiring its values, norms, language, and practices through social participation. From this perspective, learning involves not only the development of knowledge and skills but also becoming part of the collective identity of the professional group. Clinical learning environments provide opportunities for observation, practice, and feedback, but access to these opportunities may be influenced by workplace relationships. The reviewed literature highlights the importance of inclusion, mentorship and professional support within O&G training (Hong et al., 2021; Hong et al., 2022).

Whilst each of these perspectives offers a distinct explanation of workplace culture, they are also complementary. Psychological safety focuses on the interpersonal conditions required for learning, speaking up and seeking support. The hidden curriculum highlights how cultural norms and behaviours are transmitted informally through everyday workplace interactions. Communities of practice extend this understanding by emphasising participation, belonging and access to learning opportunities within professional groups. Together, these perspectives suggest that workplace culture may influence learning not only through direct experiences of

bullying or incivility, but also through its effects on participation, identity formation and engagement within clinical communities.

However, none of these perspectives fully explain the complexity of workplace culture within O&G. Psychological safety pays limited attention to structural issues such as hierarchy and organisational power, whilst communities of practice provide less insight into the mechanisms through which bullying behaviours emerge and persist. Consequently, no single theoretical perspective is sufficient to explain workplace culture in isolation. Rather, these theories provide complementary lenses through which resident experiences may be interpreted. This offers a means of examining not only whether bullying and incivility occur, but also how workplace culture shapes learning, communication, and professional development within O&G training environments.

The literature reviewed throughout this chapter demonstrates that bullying, incivility, and undermining remain recognised concerns within O&G training environments. Across a range of settings, studies have reported associations between negative workplace behaviours and outcomes including burnout, reduced wellbeing, communication difficulties, reduced confidence, and concerns regarding patient safety (Gaillard et al., 2025; Gupta et al., 2024; Hong et al., 2021; Nhundu et al., 2019). Collectively, these findings highlight workplace culture as a significant issue within the specialty.

Despite growing recognition of the problem, important limitations remain within the existing evidence base. Much of the literature relies on cross-sectional survey designs that focus on prevalence and associations with outcomes. Whilst such studies demonstrate the scale of the issue, they provide limited insight into how residents experience, interpret and respond to workplace interactions within everyday clinical practice. Existing research has also tended to examine bullying, harassment, and discrimination as discrete phenomena, providing less understanding of the broader cultural environments in which these behaviours occur.

From a medical education perspective, there remains limited exploration of how workplace culture influences learning within workplace learning environments. Although studies have identified links between bullying, confidence, communication, and willingness to seek support, the mechanisms through which these experiences shape learning remain poorly understood. Furthermore, resident voices remain underrepresented, with relatively few

studies providing detailed accounts of how workplace culture is experienced and negotiated within clinical training.

These gaps highlight the need for qualitative research that moves beyond measuring the prevalence of bullying towards understanding how workplace culture is experienced in practice. Through exploration of O&G residents' experiences, the present study seeks to generate a richer understanding of how workplace culture influences learning, professional development, and workplace participation within contemporary training environments. In doing so, it aims to contribute insights that may inform future educational and organisational interventions designed to support both resident development and safe patient care.

Chapter Two: Methodology

Research Aims and Questions

The overarching aim of this study was to explore the perceived impact of workplace bullying on O&G training across different stages of individual medical careers. The study sought to understand how bullying is experienced, interpreted, and managed within a hierarchical training environment, and how these experiences influence learning, well-being, and professional identity development.

The specific objectives were:

- To identify recurring themes and emerging patterns around bullying in O&G
- To examine whether there were any perceived educational or professional impacts of bullying.

Therefore, the study was guided by the following research questions:

1. What are residents' experiences of bullying?
2. How does workplace bullying impact residents' learning and development?

Study Design

This study adopted a qualitative design to explore the impact of workplace bullying on obstetrics and gynaecology (O&G) training at a tertiary hospital in England. Qualitative methodologies are particularly well suited to examining complex social phenomena, interpersonal dynamics, and lived experiences in professional and educational settings (Braun & Clarke, 2006; Malterud et al., 2016). Workplace bullying is a subjective, relational, and context-dependent phenomenon, often shaped by hierarchy and organisational culture, both of which are prominent in medical training environments (Einarsen et al., 2020). For this reason, quantitative approaches may underestimate prevalence, overlook context, or fail to capture the depth of impact on learning and wellbeing. In contrast, qualitative research enables participants to articulate the meanings, interpretations, and consequences of bullying in their own words.

It is worth noting that this study was informed by an interpretivist epistemological paradigm, which assumes that reality is socially constructed and that individuals may experience the same environment in different ways depending on context, position, and prior experience (Creswell & Poth, 2018). Knowledge is therefore understood as co-constructed through interaction between the participant and the researcher. This epistemological stance is particularly appropriate for exploring bullying within postgraduate medical education, where hierarchical relationships, hidden curricula, and informal norms strongly influence resident experiences (Hafferty, 1998; Lempp & Seale, 2004).

Furthermore, a semi-structured interview approach was used to allow systematic exploration of key issues while maintaining the flexibility to pursue unanticipated topics raised by participants (Kallio et al., 2016). This method enabled better comparison across interviews while supporting depth and reflexivity.

Participant Selection and Sampling Strategy

The study aimed to recruit 6 to 10 participants, including O&G residents or consultants who had undertaken speciality training within the participating NHS Trust or elsewhere and now worked within the trust within the last 3 years. According to Fugrad & Potts (2015), small projects and dissertations with 6-10 participants are considered appropriate; this study concluded with 8 participants. This allowed the inclusion of current and retrospective accounts of training culture and bullying experiences, alongside any historical experiences from other trusts whilst adhering to ethical approvals.

Within the participating Trust, there are approximately 35 resident doctors and 25 consultants in O&G, making the sample size (13.333%) proportionate and feasible. The target sample size was also informed by principles of qualitative sampling and data saturation; defined as the point at which additional interviews are unlikely to yield new themes or insights (Guest et al., 2006). Additionally, this was the point the researcher felt no new themes were emerging. A sample size like this is commonly considered as sufficient to achieve thematic saturation, particularly as participants share a defined professional context (Braun & Clarke, 2021). It was also deemed an appropriate number in line with project time constraints (12 months in total), and limitations of there being one researcher doing data collection. This meant a reduced risk of fatigue in handling large interview volumes while maintaining analytical depth and sensitivity (Kvale & Brinkmann, 2009; Pettigrew, 1990).

Sampling was purposive, as it was to include participants with direct experience of O&G training environments with potential exposure to workplace bullying. If recruitment exceeded the target, data collection would be ceased once saturation was reached to preserve analytic depth and reduce participant burden. Conversely, if early analysis suggested saturation had not been achieved, further recruitment would be considered where feasible.

To recruit participants, an internal email was sent to all O&G medics within the participating trust with basic information, alongside an attached participant information sheet (PIS). Within this email, there was a link for staff to register their interest in the study and request to be contacted with further information. Some participants preferred to respond directly to the email, internally expressing their interest. The link allowed them to state if they would like to be contacted in a different way, which was not directly linked with the trust, aiding with anonymity.

Formal statistical sample size calculation was not appropriate, as the study did not seek to generate statistically generalisable findings. Instead, analytic depth, richness of data, and reflexive engagement were prioritised.

Inclusion Criteria

Participants were eligible to enrol if they met all the following criteria:

- Currently or previously enrolled in O&G speciality training in the United Kingdom.
- Employed within the participating NHS Trust within the last 3 years.
- Willing and able to provide informed consent.

There were no restrictions based on age, gender, ethnicity, or other protected characteristics.

Exclusion Criteria

Participants were excluded if they:

- Had not undertaken O&G speciality training (e.g. medical students, Midwives, GP residents, non-training grade doctors who have not previously been enrolled in training contracts, or allied health professionals).
- Were unable or unwilling to provide informed consent.

Recruitment and participation were conducted in accordance with the Equality Act (2010), and participants were reassured that non-participation would not affect any form of their working conditions.

Data Collection

Data was collected using semi-structured interviews conducted either face-to-face or via secure video-conferencing platforms, depending on participant preference. Interviews lasted approximately 20–60 minutes.

An interview guide consisting of four open-ended questions was developed by the researcher, guided by the aims of the study and literature on: workplace bullying, postgraduate medical education, hierarchy, and professional identity formation. The questions were deliberately broad to allow participants to describe experiences in their own terms, while follow-up prompts were used to explore emotional, educational, and organisational impacts with mindful observation of any potential signs of emotional distress.

The limited number of open-ended questions allowed sufficient time for depth and reflection while minimising participant burden. The guide was piloted informally with a colleague familiar with medical training to ensure clarity and relevance, resulting in minor refinements.

All interviews were audio-recorded with consent and transcribed immediately following the interview to ensure accuracy. Identifying details were removed during transcription, and participants were assigned codes. Potentially identifiable contextual information, such as specific training levels and any academic titles, were anonymised to protect confidentiality. Following the checking of transcription, audio recordings were immediately deleted.

Reflexivity and Researcher Positioning

Reflexivity was embedded throughout the research process. Reflective notes were securely maintained following interviews and during analysis to document emotional responses, assumptions, and evolving interpretations of the researcher (Finlay, 2002). These reflections were revisited during theme development to ensure analytic decisions remained grounded in participant data rather than researcher preconceptions.

Data Analysis

The data was analysed using reflexive thematic analysis (RTA), following the six-phase framework described by Braun and Clarke (2006, 2021). RTA was selected for its theoretical flexibility, suitability for applied health and education research, and compatibility with an interpretivist epistemology.

1. Familiarisation: Repeated reading of transcripts.
2. Generating initial codes: Inductive coding of meaningful data segments across the dataset using NVivo.
3. Constructing themes: Grouping codes into broader patterns of shared meaning.
4. Reviewing themes: Iterative refinement to ensure coherence and distinctiveness.
5. Defining and naming themes: Articulating the essence of each theme and its relevance to the research questions.
6. Producing the report: Integrating themes with illustrative quotations and existing literature.

Analysis attended to similarities and differences across training levels, recognising the hierarchical structure of O&G training. An audit trail documenting coding decisions and theme development was maintained to enhance transparency (Nowell et al., 2017). Although formal member checking was not undertaken due to time and logistical constraints, findings were discussed with academic/clinical supervisors as a form of peer debriefing.

NVivo (Lumivero, 2023) qualitative data analysis software was used to support data management, coding, and organisation. NVivo facilitated systematic engagement with the dataset, enabling efficient retrieval of coded data and supporting transparency in analytic decision-making. However, analysis remained an interpretive and reflexive process by the researcher rather than the software itself.

Trustworthiness and Rigour

Trustworthiness was addressed using the criteria of credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). These criteria were selected as they provide a recognised framework for assessing the rigour and quality of qualitative research and are particularly suited to studies exploring subjective experiences and perspectives. Credibility ensures that findings accurately reflect participants' experiences, while dependability demonstrates that the research process was conducted systematically and consistently.

Furthermore, confirmability helps ensure that findings are grounded in the data rather than researcher bias, and transferability allows readers to determine whether findings may apply to similar contexts through the provision of detailed descriptions. Together, these criteria strengthen the overall trustworthiness of the study.

Likewise, credibility was enhanced through prolonged engagement with the data and use of verbatim quotations. Again, peer debriefing with supervisors supported reflexive scrutiny of analytic interpretations. Dependability was supported through detailed documentation of methodological and analytic decisions. Confirmability was addressed through reflexive practice and maintenance of an audit trail. Transferability was facilitated through contextual description, allowing readers to assess applicability to other training environments, without jeopardising anonymity.

Ethical Considerations

Ethical approval was obtained from the Oxford University Ethics Committee and the participating NHS Trust in accordance with Health Research Authority guidance and British Educational Research Association (BERA) ethical guidelines (BERA, 2018; HRA, 2023).

While the study posed minimal physical risk, it was recognised that participants might experience emotional distress when discussing sensitive personal experiences of workplace bullying. The researcher remained attentive to signs of distress throughout interviews and recalled the option to pause or terminate interviews if necessary (Illing et al., 2013). Participants were reminded that they could decline to answer any question or withdraw from the study at any time without consequence. In addition to this, support was given to the researcher in managing these interviews from a medic with psychiatric training who was not a participant in the study. This supported the researcher in recognising any signs of psychological distress or the need to end an interview and signpost to external support; although neither were present in any case throughout the research process.

Confidentiality limitations were clearly explained, particularly regarding disclosures that indicate risk of harm. There was a possibility that participants might disclose serious incidents of harassment, abuse, or unlawful behaviour. In such cases, participants were encouraged to report concerns through appropriate organisational channels. Any disclosure indicating an ongoing risk of harm to the participant or others would be escalated in line with

the participating Trust's safeguarding policies and professional duty-of-care obligations (GMC, 2022). The data was anonymised, stored securely, and managed in line with the General Data Protection Regulation (GDPR) and university policies.

Data Protection and Governance

The data was handled in accordance with the GDPR and relevant university data governance policies. Audio recordings were deleted upon checking the auto-transcription documents, as required by the participating trust. As previously discussed at this time, they were also anonymised ,with names, locations, and identifiable events being removed or altered, preventing deductive disclosure.

NVivo software was used for data management and analysis; anonymised transcripts were imported into NVivo and stored on secure institutional servers. No identifiable data was uploaded to external cloud-based platforms. Participant consent forms were stored separately from interview data to further reduce the risk of identification.

Consent forms will be retained for a minimum of 3 years to comply with Oxford University's requirements, after which they will be securely destroyed. Anonymised paper or electronic notes will be treated in the same manner as consent forms and transcripts, kept for 3 years as per Oxford University's requirements and then securely destroyed.
These measures ensured compliance with ethical and legal obligations while maintaining participant trust and confidentiality.

Safeguarding and Power Dynamics

Given the hierarchical nature of postgraduate medical training, particular attention was paid to power imbalances between participants, the organisation, and the researcher. Although participation was voluntary, it was recognised that residents may feel apprehensive about discussing bullying due to fears of reputational damage or career consequences (Illing et al., 2013).

To mitigate this risk, interviews were conducted outside working hours where possible, and participants were reassured that no identifiable information would be shared with supervisors, training programme directors, or Trust leadership. The anonymisation of the participating

Trust further reduced the risk of institutional identification, as did the option to respond to recruitment with an external email.

The researcher was mindful of their dual identity as both clinician and researcher and took care to emphasise the independence of the research.

Summary of Methodology

In summary, this study employed a qualitative, interpretivist research design to explore the impact of workplace bullying on obstetrics and gynaecology training. The use of semi-structured interviews with doctors at varying stages of training enabled in-depth exploration of experiences within a hierarchical professional environment.

The data was analysed using reflexive thematic analysis supported by NVivo software. Rigour was enhanced through reflexivity, audit trails, and adherence to established criteria for trustworthiness and ethical considerations were prioritised throughout, particularly in relation to confidentiality, safeguarding, and power dynamics.

Overall, the methodology was designed to generate contextually grounded insights into a complex and neglected aspect of postgraduate medical education.

Chapter Three: Findings

Introduction

This chapter presents the findings from the qualitative study exploring workplace culture within Obstetrics and Gynaecology (O&G), with a particular focus on resident experiences of incivility, hierarchy, and learning. The chapter begins with a detailed presentation of the specific themes derived from the data. These themes were then grouped into broader themes (as below) for ease of reading and linked with relevant existing literature. Illustrative quotations are used throughout to preserve participant voice and demonstrate analytic depth.

Research Question 1: Experiences of workplace bullying

- Organisational Culture and Structural Influences
- Interpersonal Dynamics and Equity

Research Question 2: Influence on workplace learning

- Individual Responses and Psychological Experiences
- Consequences for Professional Practice and Patient Care

Organisational culture and structural influences

Participants consistently described O&G as a speciality with a longstanding reputation for having a "toxic" or "aggressive" culture. This perception appeared to be widely internalised, with some participants framing it as an almost inevitable characteristic of the speciality. Participant 5 stated, "*Obs & gynae is historically known as a toxic work environment… It's famous for it."* This perception reflects the influence of organisational culture, whereby shared assumptions and accepted patterns of behaviour become embedded within the workplace and shape residents' expectations of the clinical learning environment (Schein, 2010). The belief that O&G is inherently toxic may contribute to the perpetuation of such behaviours, as residents come to expect and tolerate incivility. This aligns with the concept of anticipatory socialisation, whereby individuals internalise expectations about a professional culture before fully entering it (Becker et al., 1961). Such preconceptions may lower the threshold for what is considered acceptable behaviour, thereby perpetuating problematic norms.

The perception that O&G is uniquely ‘aggressive’ was attributed by participant 6 to its hybrid nature of being both a medical and surgical speciality.

> *“Obs and Gynae is unique, it's both a medical and a surgical speciality, and that means that we get both the best and the worst parts of both medical and surgical environments, which means that bullying is more common than in medical specialities and less common than your traditional surgical specialities, where they fight to get procedures.”*

This participant associated surgical environments with stricter hierarchies, time pressures, and more direct communication styles. This reflects existing literature, which identifies surgical specialities as environments where extreme authority gradients and performance pressures may foster less supportive interpersonal dynamics (Leape et al., 2012). However, attributing incivility solely to the surgical component risks oversimplifying a complex phenomenon and may diminish other contributing factors, such as organisational pressures, staffing shortages, and rooted behavioural norms.

Importantly, the normalisation of toxicity appeared to create a culture of acceptance rather than resistance. Participant 8 framed negative behaviours as ‘*just the way things are*’, stating it was ‘*to do with an existing precedent that had been set* ', indicating a degree of resignation. This is consistent with the notion of cultural reproduction, where behaviours are continued because they are perceived as normative and inevitable. As previously discussed, this is closely linked to the hidden curriculum, whereby learners absorb implicit values and behaviours that may contradict formal teaching on professionalism and respect (Larrotta et al., 2025).

The normalisation of this toxic culture may contribute to the underreporting of incivility and bullying. If such behaviours are expected, residents may be less likely to challenge them or seek support, instead internalising these experiences as part of their professional development. This is particularly concerning given evidence that normalised incivility can have cumulative negative effects on wellbeing, contributing to burnout, anxiety, and attrition (Durmus et al., 2024).

Furthermore, the framing of O&G culture as inherently difficult may serve to legitimise exclusionary practices. For example, the expectation that individuals must "fit" the culture and develop resilience.

> *"I think you do develop thick skin. You will. You develop thick skin, and I don't know if you know this, O&G has a 30% dropout rate. And I suspect some of that is people who, dare I say, can't develop the thick skin."*

This participant is echoing the notion that adapting to this behaviour is what makes residents survive throughout their training and provides longevity in the specialty. It also raises important questions about equity and inclusivity within the specialty, as it may implicitly marginalise those who struggle to adapt, including international medical graduates or individuals from different cultural backgrounds.

There is also a potential cyclical effect, whereby those who successfully adapt to or endure such environments may go on to reproduce similar behaviours as senior clinicians. This "rite of passage" narrative—where enduring hardship is seen as a marker of competence—has been described in medical training literature and may contribute to the persistence of hierarchical and, at times, punitive cultures (Lempp & Seale, 2004). Participant 2 echoed this when they stated, '*You have to work hard to prove yourself'* before bullying would stop. In this way, the normalisation of toxicity is not merely descriptive but actively generative, shaping future behaviours and expectations.

However, it is important to note that not all participants accepted this culture uncritically. Some expressed discomfort with the normalisation of incivility and questioned whether such environments are necessary or justified. When participant 8 was recounting a story in which another junior doctor was undermined by the on-call consultant, they said, '*I had pre-warned her that the person you're calling is someone who's known to be quite aggressive and rude, but somehow gets away with it. I don't know why.'* This suggests the presence of competing discourses within the speciality, with increasing frustrations and recognition of the importance of psychological safety and supportive learning environments.

The influence of individual consultants emerged as a dominant and pervasive theme, with participants 1,2,3,5,7 & 8 describing how the "tone of the day" was influenced by the

consultant or senior on call. '*The culture? It depends on who your consultant was*'. This highlights the central role of leadership in shaping workplace culture, particularly within hierarchical clinical environments.

Participants described how interpersonal relationships and consultant preferences influenced access to workplace learning opportunities. Several participants perceived that personal preferences, rather than educational need or competence, determined which residents were included in clinical experiences. Participant 3 recounted witnessing a consultant exclude a registrar from interactions throughout an entire shift, stating, *"I have witnessed a consultant who has a long-standing dislike of one of the registrars completely ignore them across the whole shift... the consultant will talk about them in front of them."* Similarly, Participant 4 described consultants allocating opportunities according to personal preference rather than fairness: *"If the consultants don't like a particular person, they will go, 'You're not doing it. [REDACTED] will do it.' And there are a few consultants that are particularly bad about that at the moment."* These accounts suggest that some consultants acted not only as senior clinicians but also as gatekeepers of learning opportunities, with interpersonal dynamics influencing equitable access to workplace-based learning. Such findings resonate with workplace learning literature, which emphasises the importance of equitable access to experiential learning opportunities (Dornan et al., 2007).

Participants consistently described inappropriate and unprofessional behaviours from senior staff, ranging from dismissive communication to overt hostility. While some consultants were perceived as 'supportive' and 'approachable', others were characterised as 'difficult', 'aggressive' or 'dismissive'. Participant 6 explained, *"You just know, if they're in a bad mood that day, then it's better just to stay away, and not call them because you know, you're just gonna get an earful and probably won't get any help anyway."* Similarly, Participant 4 reflected that *"some people are absolutely lovely, but some people are terrible."* More extreme examples of inappropriate behaviour were also described, with Participant 2 recalling an incident in which a *"blood-soaked swab was thrown at a junior doctor because they weren't doing what the surgeon wanted."* Participants reported that these behaviours extended beyond consultants to include senior midwifery staff, influencing how they navigated the workplace. As Participant 5 explained, *"If I knew that, say the coordinator was someone who wasn't particularly friendly towards junior doctors, then I would try and stay out of sight as much as possible."* These accounts suggest that exposure to inappropriate

behaviour from senior staff encouraged avoidance behaviours and contributed to feelings of anxiety, with residents adapting their actions to minimise negative interactions rather than maximise learning opportunities.
Alongside modifying their behaviour and avoiding certain individuals, some participants reported calling in sick to avoid negative interactions. Participant 7 reported:

> *'One day, I had really struggled to sleep, and it was one of those nights where if I had someone else's clinic, I probably would have gone in. But I ended up calling in sick because I was so like I cannot do [X's] clinic, having only had three hours sleep because I know [X] will be absolutely vile".*

Fear emerged as a significant mediator of behaviour, influencing both clinical decision-making and interpersonal interactions. Alongside avoiding certain consultants, participants reported delaying escalation of concerns and even pushing themselves to manage things alone so as not to bother specific consultants. Participant 7 reflected that '*our senior colleagues are the people that allow us to progress. So that's why it affects what you do'.* Such behaviours highlight the extent to which power dynamics can shape not only learning experiences and progression but also workforce wellbeing and service provision.

The presence of longstanding interpersonal conflicts between consultants further complicated the learning environment. Participant 3 reported feeling "*caught in the middle*" of these disputes, suggesting that hierarchical tensions at senior levels can cascade downwards, affecting the wider team. *"I found myself getting messages from both consultants, essentially threatening each other. But via me. And that was a very difficult situation to be in'.* This reflects the concept of organisational climate, where leadership behaviours influence the broader cultural environment (West et al., 2014).

Hierarchy was a defining feature of the O&G environment, shaping interactions across all levels of the MDT. Participants described a system in which trust and credibility were not automatically granted but had to be earned over time.

Longevity within a trust was associated with increased acceptance, improved relationships, and greater access to learning opportunities. Conversely, new, or rotating residents often experienced marginalisation, which participant 5 described as being '*guilty until proven innocent.'* This was further echoed by participant 6, who recalled, '*I was working in the*

same trust for such a long time that I was well known and liked as a result, because people felt like they could trust me.' At the same time, longevity was not universally positive. This participant then compared this with a later experience when they were at a new trust undertaking a category 1 caesarean section, which was delayed by a scrub nurse: "*she told me you've not done a section here before, so I can't trust you to prep the abdomen. And it was a cat, one section.'* Accounts like these suggest that while continuity can foster trust, it may also reinforce exclusionary practices if not actively managed. This dynamic may reflect in-group/out-group processes, where familiarity influences perceptions of competence and trustworthiness (McLeod, 2023; Tajfel & Turner, 1979). Instances where lack of trust delayed urgent interventions highlight how cultural dynamics can directly impact patient care. This is particularly concerning in high-acuity environments such as maternity care, where timely action is critical.

Overall, this theme highlights how cultural narratives surrounding O&G extend beyond individual behaviours to encompass deeply embedded expectations and social norms. The normalisation of a "*toxic*" culture not only influences how behaviours are interpreted but also shapes how they are enacted, tolerated, and perpetuated. Addressing such issues, therefore, requires not only individual behavioural change but also a broader cultural shift that challenges assumptions about what is acceptable within medical training environments.

Despite the challenges identified, there was evidence of ongoing cultural change within O&G. Participants described improvements in workplace behaviour, attributed to both formal initiatives and broader societal shifts.

Interventions such as RCOG's workplace behaviour toolkit (2021) were perceived as beneficial, although their impact appeared variable and associated with negative connotations. Participant 4 mentioned RCOG's workplace toolkit. '*The Royal College brought in this like workplace, behaviours, training, toolkit, and this was like a few years ago. And then things did change a little bit. And then I don't know whether it's a sort of generational change, but more recently, you know, people can't say anything, so people turn up to work like 20 minutes late and no one says anything because everybody's now afraid to say something out of fear that they're going to be accused of bullying or undermining*.' Concerns were raised about a perceived decline in work ethic and the challenges of providing feedback in a culture where accusations of bullying are feared by Participants 1,2,3 & 4. This suggests a complex balancing act between maintaining standards and fostering a positive

workplace culture, essentially highlighting the need to distinguish between constructive feedback and harmful behaviours. Participant 1 stated, '*If someone wants a half-hour break, and it means that someone gets their section cancelled, and I say no, I don't think you should have a break, then I'll be accused of bullying and actually, do I think that's bullying? No, I think it's looking out for the women, the poor women who have starved all day have kicked around on the Ward all day and need a section. Whereas someone says, Oh no, I can't. Because you know I've only had 10 breaks this morning, and I need another one, you know?'*

Some participants, particularly seniors, argued that harsher environments can promote learning and discipline. Participant 2 reflected, *'Those telling offs… can make you better.'* This perspective reflects traditional models of medical training, where authority and discipline are emphasised and equated with high standards. However, it stands in contrast to contemporary educational theory, which highlights the importance of supportive and learner-centred environments. While high expectations are essential in clinical practice, the way they are communicated is equally important.

Some participants expressed scepticism regarding accountability, particularly for senior staff and a lack of process when bullying does arise. Participant 2 discussed that when they said, '*I don't think the system's in place for dealing with it on a more local level.'* Proposed solutions emphasised both individual and organisational approaches, including mentorship, clear escalation policies, and increased staffing. Participant 2 also suggested '*a named individual consultant or otherwise who people can go to, talk to them about it and try and find solutions.'.*
Participant 6 noted that a clear escalation policy aided in phoning on-call consultants - '*as the resident you're protected because it's like, I'm calling you because this is what the hospital policy is so then they can't tell you off because I have to call you in, and I'll get in trouble if I don't call you in. And then if they don't come in, then it's on them.'*

Notably, several participants highlighted the importance of addressing systemic pressures within the NHS, suggesting that workload and resource constraints contribute to incivility. There was also recognition of the need to incorporate training in resilience and stress management within medical education, as participant 3 attributed a high drop-out rate to a lack of resilience '*I suspect some of that is people who, dare I say, can't develop that thick skin'.* However, as discussed previously, such interventions should complement rather than

replace efforts to address cultural and structural issues. Overall, reflecting cautious optimism, with recognition that meaningful change requires sustained effort at multiple levels.

Interpersonal Dynamics and Equity

Interprofessional relationships emerged as a complex and, at times, contentious aspect of the workplace culture. Participants described a perceived divide between doctors and midwives, often framed in adversarial terms as '*doctors versus midwives' (*participant 5), and is indicative of professional boundary tensions, which can arise from differences in training, roles, and priorities. Such divisions may be exacerbated by organisational pressures, including staffing shortages and increasing clinical demand.

The concept of horizontal violence was also evident, with participants describing bidirectional bullying between professional groups. An example of this '*us versus them'* underlying tension was provided by Participant 5 -

> '*a patient had brought in some treats, and it was very nice of them to say thank you, and they were put out in the staff room, but when we went in to have something, we were told very categorically that they weren't for us because we weren't a part of the team that delivered the woman and it felt very excluding'.*

These tensions have significant implications for teamwork and communication, both of which are critical for safe and effective patient care. Poor interprofessional relationships have been linked to adverse outcomes, reinforcing the need for interventions that promote collaboration and mutual respect. Participant 5 further proceeded to state, "*Doctors bully midwives and midwives bully doctors*." Such horizontal violence is well-documented in healthcare, and the presence of multiple hierarchies, including senior midwives, further complicates dynamics.

Although less frequently discussed, issues of race and differential treatment were clearly present within the dataset. Participant 6 reported witnessing racial bias and, in some cases, explicit discriminatory comments. '*People have openly commented on their skin colour'*.

The experiences of international medical graduates appeared particularly concerning, with reports of bullying linked to job insecurity and '*threats regarding contract renewal'* as reported by participant 8. These findings align with broader evidence of structural

inequalities within medical training, where minority groups may face additional barriers and vulnerabilities (Kline et al., 2017).

The relatively limited discussion of race within the dataset may reflect discomfort or reluctance to engage with this topic, rather than the absence of the issue. This highlights the importance of creating safe spaces for discussing discrimination and addressing systemic inequities within healthcare organisations.

Individual Responses and Psychological Experiences

Closely related to the theme of resilience was the idea of misinterpretation, particularly in relation to communication styles. Participants 1 & 3 described how certain behaviours—such as "dry humour" or abrupt feedback—might be perceived differently depending on cultural background or prior experience. Participant 1 stated:

> *"[Juniors] could they perceive that they were bullied by me, possibly because of the weird sense of humour and the dry style of my humour? I guess that means that I can be misinterpreted. I think maybe you understand my humour. I think you understand where I'm coming from. I'm not sure that all cultures would understand that in the same way."*

This was especially relevant for internationally trained doctors, who may not share the same implicit understanding of workplace norms within the UK context, highlighting the importance of cultural competence and the potential for miscommunication to exacerbate perceptions of incivility. Furthermore, Participant 3 stated, "*there's how it's delivered, but also who's delivering it. And I think that makes a big, big, big difference".* They further went on to say how pre-existing relationships formed interpretation of feedback.

> *"The example for me is my primary supervisor. I know [Y] would move mountains for me absolute mountains- so if [Y] criticises me, I can take that very, very well. Because I know regardless of the situation, I know [Y] is somebody who will look after me."*

This aligns with the concept of psychological safety, whereby individuals feel secure enough to engage in learning behaviours without fear of humiliation or punishment (Edmondson, 1999).

At the same time, participants described adaptive strategies that enabled them to navigate these challenges. Central to this was the development of rapport and trust with senior colleagues. Team continuity also emerged as a key factor in fostering resilience. Participants 2,3 & 6 who worked within stable teams reported greater confidence, improved communication, and a reduced emotional burden when receiving feedback. Conversely, frequent rotations and lack of familiarity appeared to undermine these protective factors, reinforcing the importance of relational continuity in postgraduate medical training.

Nevertheless, it is important to critically consider whether what is described as "resilience" may, in some cases, represent coping or even desensitisation to negative behaviours. While adaptation may enable individuals to function within challenging environments, it does not necessarily indicate that those environments are appropriate or conducive to learning. This distinction is crucial in avoiding the inadvertent endorsement of harmful norms.

Handover emerged as a universally negative experience, described by Participant 4 as a "*point of dread."* Going on to say, "*They'll [Consultants on call] tear you apart… It's horrible.*" Labour ward handover was uniquely positioned within the dataset as the single most discussed topic within the analysis, described by all participants as a source of significant anxiety. Rather than functioning as a collaborative and educational process, handover was frequently characterised as a performative and, at times, punitive event.

Participants described instances of public criticism, often delivered in front of large multidisciplinary audiences. Additionally, handover was described as a space where power dynamics were highly visible. Junior doctors were particularly vulnerable to scrutiny, with limited opportunity to challenge or contextualise decisions. Disagreements were often framed as individual failings rather than opportunities for shared learning, undermining the educational potential of these interactions. Participant 6 gave an example of this:

> *"The senior registrar was handing over in the morning to the consultant for the day. Both the obstetric consultant and anaesthetic consultant disagreed with her plan, and they attacked her in front of the entire handover room, so all of the night team, all of the day team, the midwife in charge, and tore apart her plan. And then started being really catty. So, she said that she'd done something, and they went, 'oh well, at least one thing's been done right', like to each other across the room. It was so demeaning. It was*

really hard to watch, uncomfortable for everyone in the room because it was just not necessary.'

These interactions were perceived as personal rather than constructive, with Participant 4's account suggesting elements of humiliation of clinical decisions. "*I'm so scared that if I have to hand over to them and if I don't know absolutely everything, they're going to tear me apart, I know that."* This aligns with literature on workplace incivility, which highlights the detrimental impact of public criticism on psychological safety and team functioning (Kohn et al., 2000).

The anticipatory anxiety associated with handover led to maladaptive behaviours, including excessive preparation and hypervigilance. Participant 4 recalls:

"They'll ask about what the patient ate for breakfast last Tuesday. And if you don't know, it's like you're an idiot, which has meant that I've been, at the end of a night shift, spending over an hour preparing for the handover when I probably could be doing other, more useful work."

Participants report spending disproportionate amounts of time preparing for handover, sometimes at the expense of other clinical duties. This shift in priorities reflects a self-protective response, where avoiding criticism becomes more salient than optimising patient care.

In some settings, the involvement of other professional groups in handover, such as midwifery managers, introduced additional layers of complexity. Participant 2 recalls another hospital where this happened regularly: "*You hand over to everybody, so senior midwives, several consultants and your decisions were picked apart".* Participant 3 gave an example of having to justify all caesarean sections performed overnight:

"I worked at a unit where at the end of every 24-hour period there would be a meeting at handover attended by all the midwifery managers where the Registrar that had done the night shift had to present all of the caesareans from the last 24 hours and that Reg was criticised heavily by the midwifery managers and all the people for why the section was done etcetera, etcetera, etcetera. Even though some of them were from the day before that the Reg had nothing to do with."

While multidisciplinary input is essential for patient care, the way information is demanded and feedback is delivered is often perceived as adversarial rather than collaborative.

This theme highlights a missed opportunity within clinical practice. When conducted effectively, handover has the potential to support learning, reflection, and patient safety. However, in this context, it appears to have become a site of performance and judgement, contributing to a culture of fear.

Consequences for Professional Practice and Patient Care

Incivility had profound effects on both learning and patient care. Participants described fear responses that impaired cognitive functioning: "*My adrenaline response was so high… I never really took that much in*." – Participant 5. The impact of incivility extended beyond emotional distress, significantly affecting both learning and clinical performance. Participant 4 described physiological stress responses, including heightened anxiety, and "*freezing*" in high-pressure situations such as theatre. These responses are consistent with the fight-or-flight mechanism and cognitive load theory, where stress reduces working memory capacity, hindering learning (Sweller, 1988). Participants 2,4,5,6 & 7 reported difficulty concentrating, reduced retention of information, and reluctance to engage actively in clinical discussions. This is consistent with educational theory, which emphasises the importance of a supportive environment for effective learning (Dweck, 2006).

Perhaps most concerning was the impact on patient safety. Fear of negative reactions from seniors led some residents to delay or avoid escalation of concerns, opting instead to manage situations independently, as stated by participant 6: "*You end up trying to manage things alone*." This behaviour introduces significant risk, as timely escalation is a critical component of safe clinical practice (Leonard et al., 2004).

Conclusion

This chapter has presented a comprehensive analysis of residents' experiences of workplace culture within Obstetrics and Gynaecology, highlighting the complex, multifaceted nature of incivility and its impact on learning, wellbeing, and patient care. Through reflexive thematic analysis, four interconnected themes were identified, illustrating how cultural norms are

shaped by hierarchical structures, individual behaviours, interprofessional dynamics, and wider organisational pressures.

A central finding is the normalisation of a “toxic” or aggressive culture within the specialty. This normalisation appears to function as a powerful socialising mechanism, shaping expectations and influencing how behaviours are interpreted and tolerated. Rather than being consistently challenged, incivility is often accepted as an inherent aspect of the specialty, reinforced through the hidden curriculum, and perpetuated across generations of clinicians.

The findings further demonstrate that workplace culture is highly variable and frequently determined by individual consultants, whose behaviours significantly influence residents’ experiences of learning and psychological safety. This variability creates an unpredictable environment in which residents must continuously adapt, often employing strategies of avoidance, emotional regulation, and selective engagement. While some degree of resilience and adaptation was described, these should not be viewed as sufficient solutions to systemic cultural issues.

Importantly, the impact of incivility extends beyond individual experience. Participants described clear consequences for learning, including reduced engagement, impaired knowledge retention, and missed educational opportunities. Of greater concern are the implications for patient safety, with fear of negative reactions from seniors contributing to delayed or avoided escalation of concerns. These findings reinforce the critical link between workplace culture, communication, and clinical outcomes.

The analysis also highlights the role of hierarchy, longevity, and belonging in shaping workplace interactions. Trust is often contingent on familiarity, creating barriers for new or rotating residents and, in some cases, directly affecting patient care. Interprofessional tensions and instances of horizontal violence further complicate the clinical environment, undermining teamwork, and collaboration. Additionally, although less frequently discussed, issues of race and differential treatment point to underlying inequities that warrant further attention.

Notably, the data reveals a tension between traditional and evolving perspectives on medical training. While some participants justified elements of incivility as necessary for maintaining standards or promoting resilience, others emphasised the importance of psychological safety

and supportive learning environments. This tension reflects a broader cultural shift within medicine, as the profession moves towards more compassionate and inclusive models of education and leadership.

Encouragingly, there was evidence of gradual cultural change, with participants identifying improvements linked to increased awareness, formal interventions, and generational shifts in attitudes. However, these changes were described as inconsistent, highlighting the need for sustained, organisation-wide efforts to address entrenched behaviours and structural challenges.

In conclusion, this study underscores that incivility within O&G is not solely an issue of individual behaviour but is deeply embedded within the cultural and structural fabric of the specialty. Addressing these challenges requires a complex approach that goes beyond promoting individual resilience to include leadership development, clear accountability mechanisms, supportive team structures, and system-level interventions. By fostering safe environments, there is potential not only to enhance resident experience but also to improve learning outcomes and patient care.

Chapter Four: Discussion

This study sought to explore Obstetrics and Gynaecology (O&G) residents' experiences of workplace culture and workplace bullying within a United Kingdom National Health Service (NHS) training environment. Through semi-structured interviews with eight current or former O&G residents, the findings highlighted the complex ways in which workplace culture is experienced throughout training. Whilst participants described a range of behaviours that could be characterised as bullying, undermining, or incivility, their accounts also revealed uncertainty regarding how such behaviours should be defined and understood within the context of a demanding clinical specialty. Experiences were shaped not only by individual interactions but also by broader organisational and educational influences. Several interconnected findings emerged relating to workplace culture, hierarchy, psychological safety, and workplace learning. These are discussed in turn below.

The findings support existing evidence demonstrating that workplace culture remains an important concern within O&G training environments (MacDougall et al., 2013; Cresswell et al., 2015; Gaillard et al., 2025). However, the present study extends current understanding by moving beyond prevalence and outcome measures to explore how residents interpret and respond to workplace interactions in everyday practice. Much of the existing literature has focused on documenting rates of bullying or examining associations with wellbeing, burnout, and job satisfaction. Whilst these studies have established that workplace mistreatment occurs, they provide less insight into how workplace culture is experienced and sustained within clinical learning environments. This study demonstrates that understanding workplace culture requires attention not only to individual behaviours but also to the social and organisational processes through which such behaviours become accepted. The discussion considers these findings in relation to existing literature and educational theory, exploring how workplace culture shapes participation, learning, and professional development within O&G training.

The purpose of this chapter is therefore not to restate the findings presented in Chapter Three, but to interpret their significance within the context of existing literature and educational theory. The discussion considers how workplace culture is reproduced and maintained in O&G training environments, explores how hierarchy and power influence learning experiences, and examines the implications of psychological safety for both resident

development and patient care. Particular attention is given to labour ward handover, which emerged as a uniquely significant finding within the dataset. The chapter then reflects upon the methodological strengths and limitations of the study before considering implications for practice and directions for future research.

Workplace Culture as a Socially Reproduced Phenomenon

A central finding of this study was that participants frequently described O&G as a specialty with a longstanding reputation for poor workplace culture. Whilst bullying, undermining, and incivility were discussed throughout the interviews, participants often framed these behaviours as symptoms of a wider cultural environment rather than isolated interpersonal incidents. Importantly, negative workplace interactions were not always described as surprising or unexpected. Instead, many participants appeared to enter the specialty with pre-existing expectations regarding the nature of O&G culture, often characterising it as aggressive, hierarchical, and difficult to navigate. This suggests that workplace culture within O&G may be sustained not only through individual behaviours but also through collective beliefs regarding what constitutes a normal training experience within this specialty.

The findings of the present study support these observations but also extend them by demonstrating how awareness of this reputation may itself influence resident experiences. Participants frequently spoke about O&G as though difficult interpersonal interactions were an expected feature of the specialty. Such as when participant 5 stated that "*Obs & gynae is historically known as a toxic work environment"* accounts like these suggest that cultural narratives surrounding O&G may become established before residents have direct experience of the environment itself.

As previously touched upon this finding can be understood through the concept of the hidden curriculum. Hafferty (1998) argues that professional values and norms are often transmitted through informal social processes rather than through formal educational structures. Participants frequently described situations in which inappropriate behaviours appeared to be accepted because they were viewed as characteristic of the specialty. Consequently, the hidden curriculum may play an important role in maintaining cultural norms by shaping expectations regarding what constitutes acceptable workplace behaviour.

The findings also suggest that workplace culture may be reproduced through a process of normalisation. Several participants described experiences that might objectively be considered humiliating, exclusionary, or inappropriate, yet simultaneously discussed such incidents as inevitable aspects of O&G training. Similar observations have been reported elsewhere within medical education research, where challenging workplace experiences have at times been framed as rites of passage through which residents demonstrate resilience and commitment to their chosen specialty (Lempp & Seale, 2004). Within the present study, participants occasionally implied that difficult interpersonal interactions were simply part of becoming an O&G clinician. Whilst such perspectives may help individuals make sense of challenging experiences, they may also reduce the likelihood that problematic behaviours are recognised and challenged.

At the same time, the findings demonstrate that workplace culture should not be understood as entirely fixed or universally accepted. Although participants frequently described O&G as possessing a difficult culture, many also expressed discomfort with this characterisation. Several questioned whether aggressive communication styles were necessary, whilst others highlighted examples of supportive consultants, positive role models, and departments where cultural improvements had occurred. These accounts suggest that competing understandings of workplace culture coexist within the specialty. Whilst some individuals appeared to accept challenging behaviours as inevitable, others viewed them as inconsistent with contemporary expectations regarding workplace wellbeing, professionalism, and education.

This tension may reflect broader changes occurring within postgraduate medical education. Increasing attention has been directed towards psychological safety and workplace wellbeing, challenging traditional assumptions that high-pressure learning environments necessarily require harsh interpersonal interactions. Participants' accounts suggest that O&G may currently be experiencing a period of cultural transition in which older models of training coexist alongside emerging expectations regarding support, inclusivity, and respectful communication. Similar tensions have been identified elsewhere within healthcare, where efforts to address bullying have occasionally been accompanied by concerns regarding maintaining professional standards and accountability (West et al., 2020).

Taken together, these findings suggest that workplace culture within O&G cannot be understood solely through individual acts of bullying or incivility. Rather, participants described a broader cultural environment in which behaviours were interpreted through

existing expectations regarding the specialty itself. The significance of this finding lies in the suggestion that workplace culture is actively reproduced through everyday interactions, professional narratives, and informal learning processes. Additionally, these findings suggest that residents learn not only clinical practice within O&G but also what behaviours, attitudes and interpersonal interactions are considered acceptable within the specialty. Workplace culture therefore shapes learning through the implicit transmission of professional norms as much as through formal education.

Hierarchy, Power, and Access to Learning

Hierarchy emerged as one of the most influential features of participants' experiences and appeared to shape not only workplace relationships but also access to learning opportunities, support, and professional development. Whilst hierarchy is an inherent feature of postgraduate medical training, participants frequently described power differentials that extended beyond clinical supervision and into everyday workplace interactions. Rather than being experienced solely as a mechanism for ensuring patient safety and graduated responsibility, hierarchy was often described as something that influenced belonging, credibility, and access to educational opportunities.

The importance of hierarchy within medical training is well recognised. Existing literature has identified power differentials as a defining characteristic of clinical learning environments, particularly within specialties characterised by high levels of responsibility and workplace-based assessment (MacDougall et al., 2013; Cresswell et al., 2015). The findings of the present study support these observations, with participants consistently describing consultants and senior clinicians as individuals who possessed considerable influence over both their working lives and educational experiences. However, whilst previous studies have largely discussed hierarchy in relation to bullying and intimidation, the present findings suggest that hierarchy may also function as a mechanism through which learning opportunities are distributed.

Several participants described situations in which access to training opportunities appeared influenced by interpersonal relationships and perceptions of competence. Consultants were frequently positioned as gatekeepers of learning, controlling access to theatre experience and procedural opportunities. As workplace learning within O&G occurs predominantly through

participation in clinical practice, restricted access to these opportunities may have important educational consequences.

This finding resonates with Lave and Wenger's (1991) theory of Communities of Practice, which proposes that learning occurs through participation within a professional community. According to this perspective, learners initially occupy positions of legitimate peripheral participation before gradually moving towards fuller participation as their knowledge, skills, and professional identity develop. Participants frequently described situations in which feelings of acceptance, trust, and belonging appeared to determine how readily they were included within workplace activities. The findings therefore suggest that workplace culture may influence learning not only through formal supervision, but also through opportunities to participate meaningfully within the clinical community.

Several participants described situations in which unfamiliarity appeared to restrict opportunities or contribute to exclusionary behaviours. This supports wider literature suggesting that learning is shaped not only by knowledge acquisition but also by inclusion and participation within professional communities (Dornan et al., 2007). Where residents feel marginalised, opportunities for engagement may be reduced.

The findings also suggest that hierarchy influences how residents respond to challenging workplace interactions. Participants frequently described modifying their behaviour in response to consultants or senior staff members, including avoiding interactions, delaying requests for support, or attempting to manage situations independently. Whilst such behaviours were discussed primarily in relation to incivility, they also have important educational implications. Learning within postgraduate medicine relies heavily upon observation, feedback, supervision, and discussion. If residents feel unable to approach senior colleagues, opportunities for workplace learning may become restricted. In this sense, hierarchy does not simply influence interpersonal relationships; it shapes the conditions under which learning takes place.

Notably, participants described considerable variation between consultants and departments, indicating that hierarchy itself was not necessarily problematic. Indeed, several participants recalled highly supportive senior clinicians who used their authority to create psychologically safe learning environments. These accounts suggest that the educational consequences of hierarchy may depend less upon the existence of power differentials and more upon how

power is exercised. This distinction is important because it shifts attention away from hierarchy as an inherently negative feature of medical training and towards the behaviours and leadership practices that shape residents' experiences within hierarchical systems.

Psychological Safety and the Educational Consequences of Incivility

Whilst participants described a range of behaviours that could be characterised as bullying, undermining, or incivility, the significance of these experiences appeared to lie less in the behaviours themselves and more in how they influenced workplace participation. Across the findings, participants described modifying their actions in anticipation of negative responses from senior colleagues. This included remaining silent during discussions and attempting to manage challenging situations independently. Such findings suggest that workplace culture may influence learning not only through direct interpersonal interactions but also through the behavioural adaptations residents develop in response to them. These findings can be usefully interpreted through the concept of psychological safety. Edmondson (1999) defines psychological safety as a shared belief that individuals can ask questions, admit uncertainty, seek assistance, and contribute ideas without fear of embarrassment, humiliation, or punishment. Within clinical learning environments, psychological safety has increasingly been recognised as an important prerequisite for learning, particularly in contexts characterised by uncertainty and complexity. Whilst the literature reviewed within Chapter One did not explicitly examine psychological safety within O&G training, many of the issues identified, including reluctance to seek support, communication difficulties, and concerns regarding escalation, are closely aligned with the concept.

This distinction is important because workplace learning within medicine is fundamentally dependent upon uncertainty. Residents are expected to ask questions, acknowledge gaps in knowledge, and seek guidance when managing unfamiliar situations. Indeed, these behaviours are generally considered markers of safe practice rather than indicators of incompetence. Yet participants frequently described environments in which exposing uncertainty carried perceived interpersonal risk. In such circumstances, residents may find themselves balancing educational and clinical needs against the desire to avoid criticism or embarrassment. The findings therefore suggest that psychological safety may influence not only how residents feel but also how they learn.

The impact of incivility on learning was also evident in participants' descriptions of cognitive and emotional responses. Several described heightened anxieties, difficulty concentrating, and reduced ability to absorb information during stressful interactions. These findings are consistent with broader educational literature demonstrating that excessive stress can impair learning by increasing cognitive load and reducing working memory capacity (Sweller, 1988). Whilst some degree of challenge is recognised as an important component of professional development, the present findings suggest that fear and humiliation may be counterproductive learning tools. Participants rarely described such experiences as motivating; instead, they frequently associated them with avoidance, self-doubt, and reduced engagement.

Importantly, the findings do not suggest that residents desired the removal of challenge, accountability, or constructive feedback. Indeed, several participants acknowledged the importance of maintaining high standards within a specialty where clinical decisions may carry significant consequences. Rather, the distinction appeared to lie in how feedback was delivered and how relationships were experienced. Criticism from trusted supervisors was often interpreted as educational and supportive, whereas similar feedback delivered within hostile or unsupportive relationships was more likely to be experienced as undermining. This finding aligns with previous work suggesting that educational relationships influence how feedback is interpreted and utilised (Watling et al., 2014). Consequently, the educational impact of feedback may depend not only upon its content but also upon the relational context in which it occurs, including the use of public feedback.

The findings also challenge the notion that resilience alone is sufficient to address workplace culture concerns. Some participants suggested that developing a "thick skin" was necessary for success within O&G. However, the widespread behavioural adaptations described throughout the dataset indicate that even experienced residents modified their actions in response to perceived interpersonal risk. This suggests that the issue may not be a lack of resilience amongst individual residents but rather the presence of environments that make participation more difficult. Framing workplace challenges solely in terms of resilience risks locating responsibility within individuals whilst overlooking the organisational and cultural factors that shape behaviour.

Taken together, these findings suggest that psychological safety provides an important lens through which workplace culture can be understood. Participants' experiences indicate that

the consequences of incivility extend beyond emotional wellbeing and into the educational processes that underpin postgraduate medical training. By influencing participation, communication, help-seeking, and engagement with learning opportunities, workplace culture may shape not only how residents experience training but also how they develop as clinicians. Consequently, fostering psychologically safe learning environments may be important not only for resident wellbeing but also for effective workplace learning and professional development.

Labour Ward Handover as a Unique Educational and Cultural Space

One of the most striking findings to emerge from this study was the prominence of labour ward handover within participants' accounts. Whilst the original interview schedule did not specifically focus on handover, all participants discussed labour ward handover at some stage during their interviews, often in considerable detail. Participants consistently described handover as a source of apprehension, anxiety, and scrutiny, with several identifying it as one of the most challenging aspects of working within O&G. The prominence of handover within the dataset suggests that it occupies a particularly important position within workplace culture and may represent a key site through which cultural norms are communicated and reinforced.

Existing literature has highlighted the importance of handover for patient safety, continuity of care, and communication within healthcare teams (Kohn et al., 2000). Within O&G specifically, effective communication during handover is recognised as an essential component of safe clinical practice, particularly in high-acuity environments characterised by frequent changes in patient condition and rapid decision-making. However, whilst previous literature has focused primarily on the procedural and safety aspects of handover, participants in the present study described it as something far more socially and emotionally significant. Rather than functioning solely as a mechanism for transferring clinical information, handover appeared to serve as a highly visible arena in which competence, credibility, and professional legitimacy were publicly evaluated.

Participants frequently described handover as a performative event in which they felt exposed to scrutiny from senior clinicians and the wider multidisciplinary team. Accounts of public questioning, criticism, and challenge were common throughout the dataset. Importantly, participants rarely objected to having their clinical decisions reviewed. Instead, concerns centred on the manner in which these discussions occurred and the perceived consequences

of making mistakes in a public setting. The findings therefore suggest that handover was experienced not merely as an educational discussion but as an event in which residents felt their professional competence was being judged before an audience.

Edmondson (1999) argues that learning environments are most effective when individuals feel able to acknowledge uncertainty and engage in open discussion without fear of humiliation. Participants' accounts suggest that labour ward handover frequently lacked these characteristics. Rather than encouraging discussion and collective learning, some handovers appeared to create conditions in which residents felt compelled to protect themselves from criticism. This was evident in descriptions of excessive preparation, hypervigilance, and anxiety regarding potential questioning. Several participants reported spending significant amounts of time preparing for handover, not necessarily because doing so improved patient care, but because they feared the consequences of being unable to answer questions posed by senior colleagues.

The educational implications of this finding are particularly noteworthy. Handover represents a potentially valuable learning opportunity. It provides opportunities for reflection, discussion of clinical reasoning, exposure to alternative approaches, and feedback from experienced clinicians. In principle, such discussions should support workplace learning and professional development. However, participants frequently described handover as a space in which self-protection became prioritised over learning. Where fear of criticism dominates, individuals may become more concerned with avoiding mistakes than engaging in critical reflection. Consequently, a process intended to facilitate learning may inadvertently discourage the openness and curiosity required for effective educational dialogue.

An additional consideration is the potential impact of handover culture on professional identity formation. Several participants described feeling that their competence was judged according to their performance during handover rather than solely through their broader clinical practice. Experiences of public criticism appeared capable of shaping confidence, self-perception, and willingness to participate in future discussions. Medical education literature increasingly recognises that professional identity develops through workplace interactions and experiences of belonging within professional communities (Cruess et al., 2015). The findings of the present study suggest that labour ward handover may play an important role in this process, influencing not only what residents learn but also how they come to view themselves as clinicians.

Importantly, participants' accounts indicate that the difficulties associated with handover were not inevitable consequences of reviewing complex clinical decisions. Several contrasted negative experiences with examples of consultants who facilitated discussion in a supportive and educational manner. Challenging clinical decisions and discussing alternative approaches are fundamental components of postgraduate medical education. However, the findings suggest that educational value may be diminished when such discussions are experienced as punitive rather than developmental.

The prominence of labour ward handover within the dataset therefore represents an important contribution of the present study. Whilst previous research has identified bullying, incivility, and communication difficulties within O&G training, labour ward handover emerged as a specific setting in which many of these issues appeared concentrated. It functioned simultaneously as a clinical process, educational opportunity, social interaction, and demonstration of hierarchy. Understanding handover in this way moves discussion beyond individual behaviours and towards consideration of how workplace structures themselves may shape learning experiences. Future efforts to improve workplace culture within O&G may therefore benefit from paying particular attention to the conduct and educational function of labour ward handover, given its apparent influence on psychological safety, participation, and professional development.

Resilience, Misinterpretation, and the Complexity of Defining Bullying

An important finding of the present study was the complexity with which participants understood and interpreted workplace bullying. Whilst experiences of incivility, exclusion, and intimidation were frequently described, participants did not always agree on where the boundary between bullying and acceptable workplace behaviour should be drawn. Rather than presenting a straightforward narrative in which all negative interactions were viewed as inappropriate, many participants described uncertainty regarding how particular behaviours should be interpreted. This finding reflects the challenges identified within existing literature, where definitions of bullying remain contested, and experiences are often shaped by context, intent, and individual perception (Einarsen et al., 2020).

This ambiguity was particularly evident in discussions surrounding feedback and supervision. Several participants differentiated between criticism intended to improve clinical practice and behaviour perceived as personally humiliating or degrading. This distinction echoes

arguments within the literature that effective supervision sometimes requires challenge, particularly in specialties where patient safety concerns are significant (MacDougall et al., 2013). However, participants also recognised that challenge becomes problematic when it is experienced as disproportionate, repeated, or targeted towards an individual rather than a clinical issue. The findings therefore support existing arguments that bullying cannot be understood solely in terms of observable behaviours but must also be considered within the broader interpersonal and organisational context in which those behaviours occur.

Participants also raised questions regarding resilience and the extent to which individual responses influence perceptions of workplace interactions. Some suggested that contemporary residents may interpret behaviours differently from previous generations, whilst others argued that resilience remains an important component of working within demanding clinical environments. Similar debates have been identified within wider medical education literature, where concerns regarding resident wellbeing occasionally coexist with narratives emphasising personal resilience and adaptability. Within the present study, however, participants rarely presented resilience as a complete solution to workplace culture challenges. Instead, resilience appeared to be discussed as one factor amongst many influencing how individuals responded to difficult experiences.

The findings therefore highlight an important tension. On one hand, participants acknowledged that individuals may vary in how they interpret and respond to workplace interactions. On the other hand, there was widespread recognition that certain behaviours were consistently associated with fear, avoidance, and distress.

An additional layer of complexity emerged in discussions relating to cultural differences and international medical graduates. Several participants suggested that humour, communication styles, and workplace expectations may be interpreted differently according to previous experiences and cultural backgrounds. In particular, references to "dry humour" and indirect communication highlighted the possibility that misunderstandings may occasionally contribute to perceptions of incivility. Such findings are consistent with literature demonstrating that communication is influenced by social and cultural context. However, it is important to avoid oversimplifying negative experiences as mere misunderstandings. Whilst differences in interpretation may contribute to some workplace tensions, participants also described examples of overt exclusion, discrimination, and inappropriate behaviour that extended beyond issues of communication style alone.

The findings also raise questions regarding the relationship between resilience and the hidden curriculum. Participants occasionally described the development of a "thick skin" as an expected part of O&G training. Such accounts suggest that resilience may function not only as an individual characteristic but also as a cultural expectation. From this perspective, residents may learn that successful participation within the specialty requires adaptation to existing norms rather than challenging them. This is particularly significant when considered alongside earlier findings regarding cultural reproduction and normalisation. If enduring difficult workplace interactions becomes viewed as evidence of professional commitment or competence, there is a risk that problematic behaviours become legitimised through the language of resilience.

At the same time, the findings suggest that resilience and psychological safety should not be viewed as opposing concepts. Participants frequently described supportive consultants and positive workplace relationships as factors that enhanced their confidence and ability to cope with workplace challenges. This indicates that resilience may develop most effectively within supportive environments rather than through exposure to hostility or intimidation. Such an interpretation aligns with contemporary perspectives on resilience, which increasingly emphasise the importance of organisational and social factors rather than locating responsibility solely within individuals.

These findings demonstrate that bullying within O&G cannot be understood as a simple or universally agreed phenomenon. Participants' accounts revealed ongoing negotiation regarding what constitutes acceptable behaviour, how challenging interactions should be interpreted, and where responsibility for managing such experiences lies. Whilst this complexity should not diminish concerns regarding workplace culture, it highlights the importance of avoiding overly simplistic explanations. The findings suggest that workplace bullying exists within a broader context shaped by professional expectations, cultural norms, interpersonal relationships, and individual interpretation. Recognising this complexity may be essential for developing interventions that address workplace culture without reducing the issue to either individual vulnerability or individual misconduct alone.

Implications for Patient Safety

Although the present study focused primarily on residents' experiences of workplace culture, the findings also provide insight into what residents learn about patient safety through their

everyday workplace experiences. Participants' accounts suggest that workplace culture shapes not only communication and help-seeking behaviours but also residents' understanding of when it is acceptable to seek support, challenge senior colleagues and escalate clinical concerns. Previous research has identified associations between bullying, communication difficulties, reduced team functioning and concerns around patient care (Gaillard et al., 2025; Nhundu et al., 2019). Whilst the present study was not designed to examine patient outcomes directly, it suggests that workplace culture may influence patient safety indirectly by shaping the behaviours and professional norms that residents learn within clinical practice.

Participants frequently described delaying escalation, avoiding particular senior clinicians, or attempting to manage clinical situations independently before seeking support. Whilst these behaviours were often motivated by a desire to avoid negative interpersonal interactions rather than compromise patient care, they have potential implications for communication and decision-making within high-risk clinical environments such as O&G. These behaviours therefore represent not only responses to negative workplace experiences but also learned adaptations to the prevailing workplace culture.

Importantly, the relationship between workplace culture and patient safety is unlikely to be straightforward. The present study cannot determine whether negative workplace experiences resulted in adverse patient outcomes, nor was this the aim of the research. However, the findings suggest that workplace culture influences behaviours recognised as fundamental to both workplace learning and safe clinical practice, including communication and escalation. Participants' accounts indicate that repeated exposure to hierarchical and intimidating cultures may implicitly teach residents that avoiding conflict with senior colleagues is preferable to speaking up, even in situations where escalation could benefit patient care. Consequently, improving workplace culture represents not only an organisational priority but also an educational one, as the behaviours and values reinforced within clinical environments are likely to shape residents' understanding of safe professional practice.

Addressing the research questions

Taken together, these findings answer the study's two research questions. First, residents experienced workplace culture as a complex interaction between organisational norms, hierarchy, interpersonal relationships, and educational practices, rather than as isolated acts of bullying. Second, workplace culture shaped how residents learned and participated within the clinical environment both negatively and positively depending on their experience. Collectively, these findings demonstrate that workplace culture functions not simply as the setting in which learning occurs, but as an active educational influence that shapes what residents learn about professional practice and how they learn it.

Methodological Considerations

This study adopted a qualitative approach using semi-structured interviews and reflexive thematic analysis to explore O&G residents' experiences of workplace bullying and workplace culture. Given the exploratory nature of the research question, this approach was considered appropriate as it enabled participants to provide detailed accounts of their experiences and allowed for examination of the meanings they attached to workplace interactions. Whilst survey-based studies have provided valuable information regarding the prevalence of bullying within O&G, they offer limited insight into how such experiences are understood and negotiated within everyday clinical practice. The qualitative methodology therefore allowed exploration of dimensions of workplace culture that may not be captured through quantitative approaches alone.

The use of reflexive thematic analysis was particularly valuable in identifying patterns across participants' accounts whilst retaining sensitivity to contextual differences between experiences. Unlike methodologies that seek to establish a singular underlying reality, reflexive thematic analysis acknowledges the active role of the researcher in knowledge production and recognises that themes are generated through engagement between researcher, participants, and data (Braun & Clarke, 2022). This approach aligned closely with the study's aim of understanding how residents interpreted workplace experiences rather than establishing objective measures of bullying.

The researcher's position as a midwife working within maternity services provided both strengths and challenges. Familiarity with clinical environments facilitated rapport during interviews and enabled nuanced understanding of organisational structures, workplace

terminology, and contextual factors that may have been less accessible to an external researcher. Participants may have felt more comfortable discussing sensitive experiences with someone who possessed insight into the realities of maternity practice. However, this insider position also created the potential for assumptions and preconceptions to influence data interpretation because they were present on the more junior side of the professional groups. Maintaining a reflexive journal throughout the research process supported critical reflection regarding these influences and encouraged ongoing consideration of how personal experiences may shape analysis.

The use of purposive sampling allowed recruitment of participants with direct experience of O&G training. Whilst purposive sampling ensured participants possessed direct experience of O&G training, it was a very sensitive topic, and it is possible that residents with particularly strong views regarding workplace culture were more likely to participate. Inclusion of residents from different stages of training provided a range of perspectives and enabled exploration of workplace culture across varying levels of seniority. Although the sample size was relatively small, this is consistent with qualitative research seeking depth rather than breadth of understanding. The richness of participants' accounts and recurrence of key themes suggest that the study generated sufficient information power to address the research question.

Strengths and Limitations

A key strength of this study lies in its exploration of workplace bullying through a medical education lens. Whilst existing literature has frequently focused on prevalence, burnout, and wellbeing outcomes, the present study examined how workplace culture influences participation, learning, and professional development. This allowed consideration of bullying not only as an occupational issue but also as a phenomenon with important educational implications. The identification of labour ward handover as a particularly significant site within participants' experiences also represents a novel contribution, highlighting an aspect of workplace culture that has received relatively limited attention within existing O&G literature.

The study also benefited from rich qualitative data generated through in-depth interviews. Participants were willing to discuss complex and, at times, emotionally challenging experiences, providing nuanced accounts that extended beyond simple descriptions of

workplace incidents. The inclusion of residents from different stages of training further strengthened the study by allowing consideration of experiences across varying levels of responsibility and professional development.

Several limitations should also be acknowledged. The study was conducted within a single NHS organisation and therefore reflects majority of experiences within a specific institutional context, although some residents, particularly more senior ones, have had experiences within other trusts. Workplace culture is shaped by local leadership, staffing, organisational history, and departmental practices, meaning findings may not be transferable to all O&G training environments. In addition, participation was voluntary, and it is possible that individuals with particularly positive or negative experiences were more likely to take part.

As with all interview-based research, participants' accounts were subject to retrospective interpretation. Experiences may have been influenced by recall bias, subsequent reflection, or changing perceptions over time. Furthermore, the findings represent participants' understandings of events rather than objective accounts of workplace interactions. However, given that the study sought to explore lived experiences and perceptions, such subjectivity should be viewed as an important aspect of the data rather than a methodological weakness.

An additional limitation relates to issues of race, ethnicity, and discrimination. Although race and ethnicity did not feature prominently within the final thematic structure, several participants made brief references to discrimination and differential treatment. The limited discussion of these issues should not be interpreted as evidence that race was unimportant within participants' experiences. Experiences of discrimination are often difficult to discuss openly, particularly within small professional communities where concerns regarding identification, professional relationships, or future career progression may exist. Furthermore, the interview schedule was not specifically designed to explore racialised experiences of workplace culture. It is therefore possible that important dimensions of race and ethnicity remained unspoken or were embedded within broader discussions regarding hierarchy, belonging, and exclusion. The relative absence of race from the final themes may therefore reflect the challenges associated with discussing discrimination rather than the absence of discrimination itself. Future research designed specifically to explore the intersection between race, workplace culture, and bullying within O&G training may provide important additional insights.

Future Research and Conclusion

The findings of this study highlight several opportunities for future research. Given the prominence of labour ward handover within participants' accounts, further exploration of handover culture across multiple training sites would be valuable. Research examining how handover is experienced by consultants, midwives, and other members of the MDT may also provide a more comprehensive understanding of the cultural dynamics operating within these settings. In addition, future studies could explore interventions aimed at enhancing psychological safety and evaluate their impact on learning, communication, and resident experience.

Further investigation into the experiences of international medical graduates and residents from ethnic minority backgrounds may also be warranted. Whilst race and ethnicity did not emerge as dominant themes within the present study, participants' brief references suggest that these factors may influence experiences of workplace culture in ways that were not fully captured within the current research design.

In conclusion, the findings suggest that workplace bullying within O&G cannot be understood solely as a series of isolated interpersonal incidents. Rather, participants described experiences embedded within broader cultural, organisational, and educational structures that influenced how they learned, communicated, and participated within clinical practice. Workplace culture appeared to shape not only wellbeing but also access to learning opportunities, willingness to seek support, and development of professional identity. The prominence of labour ward handover, the influence of hierarchy, and the importance of psychological safety collectively highlight the complex relationship between workplace culture and postgraduate medical education. Addressing workplace bullying may therefore require approaches that move beyond individual behaviours and instead consider the wider cultural conditions through which such behaviours are produced, maintained, and experienced.

Chapter Five: Conclusion

Introduction

This study set out to explore Obstetrics and Gynaecology (O&G) residents' experiences of workplace culture and workplace bullying within a United Kingdom, National Health Service (NHS) training programme. Whilst concerns regarding bullying, undermining and incivility within O&G have been widely acknowledged within existing literature, much of the available evidence has focused upon prevalence, organisational outcomes, and resident wellbeing. Comparatively little research has explored how residents themselves experience these behaviours within everyday clinical practice or considered the implications of workplace culture from a medical education perspective. By adopting a qualitative approach, this study sought to move beyond measuring the occurrence of bullying to develop a richer understanding of how workplace culture is experienced and interpreted.

Through semi-structured interviews, participants described their experiences of workplace culture, hierarchy and workplace learning within O&G. Reflexive thematic analysis generated four interconnected themes, demonstrating that experiences of workplace bullying were shaped not only by individual interactions, but also by wider organisational and cultural influences. Participants described a workplace characterised by longstanding cultural expectations, variable leadership, complex hierarchical relationships, and differing interpretations of what constituted bullying within a demanding clinical environment. These experiences influenced confidence, participation, communication, and engagement with workplace learning, highlighting the close relationship between organisational culture and postgraduate medical education.

This chapter draws together the key conclusions of the study. It evaluates how the study has addressed the research question, considers its contribution to medical education, explores the implications for educational practice and organisational development, and outlines areas for future research.

Answering the Research Question

The research sought to answer the question:

"What are Obstetrics and Gynaecology residents' experiences of workplace bullying?"

The findings suggest that there is no single accepted answer. Instead, participants' experiences demonstrate that workplace bullying is interpreted through the interaction of organisational culture, hierarchy, professional expectations, and educational context.

Participants consistently experienced workplace bullying as culturally embedded rather than sporadic. Whilst individual examples of incivility, exclusion and undermining were described throughout the interviews, these were rarely discussed as isolated events. Instead, participants viewed such behaviours as manifestations of a wider workplace culture that had become normalised over many years. This distinction is important because it shifts understanding away from identifying individual perpetrators towards recognising the organisational and cultural conditions within which bullying behaviours become accepted.

A second important finding, participants demonstrated considerable uncertainty regarding the boundaries of workplace bullying. Many recognised that O&G requires direct communication, rapid decision-making, and robust clinical challenge. Consequently, residents often questioned whether interactions reflected unacceptable behaviour or simply represented the realities of practising within a high-pressure specialty. This ambiguity appeared to influence reporting behaviours and contributed to the normalisation of incivility, with some participants accepting behaviours they might previously have considered inappropriate.

Hierarchy also fundamentally shaped participants' experiences. Relationships with senior clinicians influenced confidence, educational opportunities, and both direct and indirect participation. Positive consultant role models fostered environments characterised by support and constructive feedback, whereas negative interactions often led to avoidance behaviours, reduced participation, and reluctance to seek assistance. Importantly, these differences were frequently attributed to individual leadership styles rather than organisational policies, illustrating how workplace culture may vary considerably even within the same department, let alone across trusts.

The findings demonstrate that the effects of bullying are not confined to emotional well-being but also shape learning within clinical practice. Participants described modifying their behaviour to minimise criticism, preparing extensively for handover to avoid embarrassment (at the expense of clinical work) and delaying requests for help because of concerns regarding negative responses. Such behaviours have important educational implications as workplace

learning depends upon active participation, questioning, reflection, and willingness to acknowledge uncertainty. When these behaviours are replaced by self-preservation, learning opportunities become restricted despite educational structures remaining unchanged.

Finally, participants' accounts illustrate that workplace bullying influences professional identity formation. Throughout training, learners continuously construct understandings of what it means to become an obstetrician or gynaecologist. These understandings develop not only through formal teaching but through observation of everyday workplace interactions. Participants frequently described learning what behaviours were rewarded, tolerated, or discouraged by watching how senior clinicians interacted with colleagues. Consequently, workplace culture shaped not only what residents learned but also who they believed they needed to become to belong within the profession.

The findings indicate that O&G residents experience workplace bullying as a complex educational phenomenon embedded within broader organisational culture. Instead of existing as separate influences, bullying, hierarchy and psychological safety shape residents' participation, communication, confidence, and professional development throughout training.

Contribution to Medical Education

This study extends existing understanding of workplace culture by examining how O&G residents experience and interpret everyday workplace interactions. Whilst previous studies have established that bullying, undermining, and incivility remain concerns within O&G (MacDougall et al., 2013; Cresswell et al., 2015; Gaillard et al., 2025), the existing evidence has focused upon quantifying these behaviours or examining their associations with burnout, wellbeing, and workforce retention. Comparatively less attention has been paid to the educational processes through which workplace culture influences learning and participation in clinical environments.

The findings of the study suggest that workplace culture should be understood not solely as an organisational issue but as a fundamental component of postgraduate medical education.

Participants' accounts suggest that many of the most influential lessons encountered during training were communicated informally through everyday workplace interactions over formal teaching. Behaviours displayed by senior clinicians conveyed implicit messages regarding

authority, conduct, and expectations of junior doctors. These observations support Hafferty's (1998) conceptualisation of the hidden curriculum while illustrating how workplace culture may reinforce behavioural norms. In doing so, the findings highlight the importance of recognising that professional identity develops not only through structured teaching but also through participation within workplace cultures.

The most significant contribution of this study is the identification of labour ward handover as a distinctive educational and cultural space within O&G training. Although handover was not included within the interview schedule, every participant discussed it extensively, suggesting that it occupies a central position within residents' experiences of workplace culture. Participants frequently described preparing extensively for handover, anticipating questioning from senior clinicians, and modifying their behaviour in response to previous experiences of public criticism. Importantly, residents did not object to the clinical challenge itself. Instead, their concerns related to the way challenge was delivered and the public nature of these interactions. Consequently, labour ward handover appeared to function simultaneously as a learning opportunity, an assessment environment, a demonstration of hierarchy and a mechanism through which workplace culture was communicated to successive residents. By conceptualising labour ward handover in this way, the study shifts attention towards one of the principal mechanisms through which workplace culture is reproduced within O&G training.

Implications for Educational Practice and Organisational Development

The findings of this study have implications for postgraduate medical education at individual, educational and organisational levels. Whilst workplace bullying is frequently addressed through policies relating to professionalism or disciplinary procedures, participants' accounts suggest that meaningful improvements in workplace culture are unlikely to be achieved through individual behavioural interventions alone. Instead, attention should also be directed towards the organisational environments within which these behaviours occur and the educational practices that either reinforce or challenge existing cultural norms.

Educationally, the findings highlight the importance of developing psychologically safe learning environments. Consultants and senior clinicians occupy influential educational roles; their everyday interactions with residents shape learning opportunities, confidence and contribute to the development of professional identity. Educational development programmes

should therefore continue to extend beyond clinical skills to include communication, feedback delivery, and leadership skills. Such approaches would align with increasing recognition that effective clinical educators require expertise not only in technical knowledge but also in the interpersonal skills that facilitate workplace learning.

Furthermore, labour ward handover represents an important opportunity for educational development. Rather than viewing handover solely as a process for transferring clinical information, departments may benefit from recognising its educational function. Consultants facilitating handover should be encouraged to promote positive questioning, discussion and reflective learning whilst maintaining appropriate clinical challenge. Creating environments in which residents feel able to explain clinical reasoning and acknowledge uncertainty may enhance both educational outcomes and patient safety.

At an organisational level, workplace culture should be recognised as a shared responsibility rather than an issue attributable to individual personalities alone. Although participants frequently identified particular consultants as having substantial influence over departmental culture, the variability between positive and negative experiences demonstrates that supportive workplace environments are achievable within existing healthcare systems. Organisations should therefore continue investing in leadership development, mentoring opportunities and initiatives that promote respectful multidisciplinary working. Interventions aimed solely at improving individual resilience are unlikely to address the systemic factors identified throughout this study. Instead, organisational efforts should focus upon creating workplace cultures that encourage openness, collaboration and constructive feedback whilst maintaining high professional standards.

Summary of the Study

Existing literature has consistently demonstrated that bullying, undermining, and incivility remain recognised concerns within O&G training, with associations reported between workplace mistreatment, burnout, reduced well-being, and resident attrition. However, previous research has predominantly relied upon quantitative survey methods, providing limited insight into how residents interpret these experiences or how workplace culture influences learning in everyday clinical practice.

To address this gap, an interpretivist qualitative methodology was adopted using semi-structured interviews with eight current and former O&G residents working within a UK NHS Trust. Reflexive thematic analysis allowed participants' accounts to be explored in depth, generating themes grounded in lived experience rather than predetermined theoretical assumptions. This approach acknowledged workplace bullying as a socially constructed phenomenon, acknowledging that individuals may interpret similar experiences differently according to context, relationships, and previous experiences.

The findings demonstrated that workplace bullying was rarely experienced as isolated interpersonal conflict. Instead, participants consistently situated negative interactions within a broader organisational culture that they described as historically aggressive, hierarchical, and intimidating. Many entered the specialty already anticipating difficult workplace relationships, suggesting that cultural expectations had become embedded within the professional identity of O&G itself. Such expectations appeared to influence both how behaviours were interpreted and the extent to which they were challenged, illustrating the powerful influence of the hidden curriculum upon postgraduate training.

Hierarchy consistently shaped residents' experiences throughout postgraduate training. Consultants were frequently described as having considerable influence over the educational environment, influencing both access to learning opportunities and the psychological climate in which residents learned. Importantly, participants did not object to challenge or critical feedback themselves. Rather, they distinguished between educational challenge delivered constructively and behaviours perceived as humiliating, dismissive or unnecessarily punitive. This finding highlights the complexity of defining workplace bullying within healthcare environments characterised by high clinical responsibility with frequent performance evaluation.

Perhaps the most significant finding was the prominence of labour ward handover. Although the interview schedule did not specifically focus on handover, every participant discussed it extensively, describing it as a setting associated with scrutiny, anxiety, and public evaluation. Handover functioned not only as a mechanism for transferring clinical information but also as a cultural space in which hierarchy, professional identity and workplace expectations were enacted and reinforced. Participants frequently described modifying their behaviour in anticipation of criticism, illustrating how educational opportunities could become overshadowed by concerns regarding reputation and public performance.

Recommendations for Future Research

The findings of this study identify several opportunities for future research. Given the relatively small sample size, further qualitative research involving residents from multiple training programmes would help determine whether the experiences described within the present study reflect broader patterns across the entire UK O&G training. Comparative studies involving other medical and surgical specialties may also provide valuable insight into whether the presence of hierarchy and poor culture is a feature unique to O&G or reflects wider characteristics of postgraduate medical education.

The prominence of labour ward handover within this study suggests that it warrants dedicated investigation. As this theme emerged inductively rather than through direct questioning, future research should explore handover as both a clinical and educational process. Observational or ethnographic studies may provide a richer understanding of how hierarchy, communication and professional identity are enacted during these interactions. Incorporating the perspectives of consultants, midwives, and other members of the multidisciplinary team would further develop understanding of its educational function.

Future research should also evaluate interventions designed to improve psychological safety within postgraduate training environments. Whilst educational initiatives promoting respectful communication, civility and human factors have shown promise, further evidence is required to establish their long-term influence upon workplace culture. Longitudinal research exploring how workplace culture changes throughout specialty training would also contribute to understanding how professional identity develops within supportive and unsupportive learning environments.

Finally, participants made occasional references to issues relating to race, ethnicity, and differential treatment. Although these themes did not emerge prominently within the present study, future research specifically designed to explore the experiences of international medical graduates and residents from ethnic minority backgrounds may provide important additional insight into the intersection between workplace culture and inclusion in postgraduate medical education.

Conclusion

This study has demonstrated that workplace bullying within Obstetrics and Gynaecology cannot be understood simply as a series of isolated interpersonal encounters. Instead, participants described experiences deeply embedded within broader organisational and cultural structures. Workplace culture shaped not only residents' wellbeing but also their willingness to seek support, engage with learning opportunities and develop professional confidence. These findings reinforce the importance of understanding workplace bullying as an educational issue as much as an organisational or occupational one.

The study further demonstrates that hierarchy remains a defining feature of O&G training. Whilst participants recognised the necessity of clinical challenge within a high-risk specialty, they consistently distinguished between rigorous educational supervision and behaviours experienced as intimidating, dismissive, or humiliating.

Perhaps the most significant contribution of this research is the identification of labour ward handover as a central educational and cultural space within postgraduate training. It was within this environment that many residents experienced their greatest sense of scrutiny, but also where opportunities existed for constructive feedback, reflection, and learning.

Improving workplace culture requires more than addressing individual acts of bullying or encouraging greater resilience amongst residents. It requires sustained attention to the educational environments in which clinicians learn, participate, and develop. Ultimately, the findings of this study suggest that labour ward handover represents one of the most influential yet under-recognised educational spaces within O&G training. Viewing handover as more than a process of clinical communication, and recognising its role in shaping workplace culture, provides an opportunity to strengthen psychological safety, enhance workplace learning, and improve patient care.

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Appendix

A)

WHAT	**WHO**	**WHEN**	**HOW**
Topic	**Population**	**Temporal /time**	**Methodology (Type of research)**
Bullying Workplace Bullying Horizontal Violence Intimidation Incivility	Residents Doctors Residents	Obstetrics training Residency In O&G OBGYN	Qualitative and Quantitive Systematic reviews Meta-analysis

B)

Inclusion Criteria	Rationale	Exclusion Criteria	Rationale
Primary research.	To allow for original analysis and critiquing.	Papers prior to 2018.	To use the most current papers allowing for the most relevance and up-to-date evidence in practice.
Systematic Reviews.	To allow for more data, other authors thoughts and analysis.	A non-English language.	To allow for thorough and accurate reading and interpretation.
Residents Experience.	To gain insight into resident's experiences and gain their perspectives.	Full text inaccessible online.	To allow for thorough and accurate reading and interpretation.
O&G specialty only	To gain insight into residents direct experiences within this specialty only.	Mention of any speciality outside of O&G.	To allow for direct relevance with obstetric training and practice.

C)

What are O&G residents' experiences of workplace bullying?
PARTICIPANT INFORMATION SHEET
Central University Research Ethics Committee Reference: AP02 / **Ethics reference:**
Education (Educ) DREC – 2423295
Response link: O&G residents participation – Fill in form

Introductory paragraph

You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the

following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether you wish to take part.

Why is this project being conducted?

This project aims to explore experiences of bullying during O&G training, to identify recurring themes
and potential strategies to prevent and address systemic bullying.

Why have I been invited to take part?

You are being invited to take part in this project because you are or have been a resident in Obstetrics & Gynaecology and currently work within UHCW NHS Trust.

Do I have to take part?

No. It is up to you to decide whether to take part. You can withdraw yourself from the research, without giving a reason, and without negative consequences, by advising me/ a member of the team of this decision.
Your data will be anonymised as soon as possible following the interview. You can choose to stop and withdraw your data from the study at any point during the interview, in which case any collected data will be immediately destroyed. You can also choose to withdraw your data at the conclusion of the interview, should you wish to do so. After this point, your data will be anonymised as soon as possible, and thus be unable to be withdrawn from the study
Participants' interview data will be removed from the project records, and any records with associated identifiable information securely destroyed. All withdrawal procedures will be conducted in accordance with Oxford University data protection policies, and your decision will remain confidential.

What will happen to me if I take part in the research?

The research will take place either in person on UHCW NHS Trust premises or online via Microsoft Teams, depending on your preference. If meeting in person, you will be informed of the agreed location in advance and what to expect on arrival. Before the interview begins, you will have the opportunity to ask questions, and your written consent will be obtained. Your involvement in the research will consist of one interview lasting up to one hour, though it may be shorter. The interview will involve 4 open-ended questions about workplace bullying within O&G, including your understanding of bullying, experiences (if any), why you think it occurs, and how it might be addressed. The questioning style will be conversational and flexible, allowing you to shape the depth of your responses. With your consent, the interview will be audio-recorded so that an accurate account of our conversation can be transcribed prior to being deleted; no video recordings or photographs will be taken. This is the only research activity required—there are no follow-up sessions—and you may request a pause or stop the interview at any time. If the interview extends or you require a break, this will be offered.

What are the possible disadvantages and risks in taking part?

Some of the topics discussed in this project—particularly experiences of workplace bullying—may be emotionally uncomfortable or distressing. You may skip any question, pause the interview, or stop entirely at any time without giving a reason. There are no physical risks associated with taking part. While every effort will be made to protect your identity, experiences shared in a small clinical specialty may carry a theoretical risk of indirect identification. To minimise this, all transcripts will be fully anonymised, with names, roles, locations, and any other identifying details removed or generalised, and only anonymised data will appear in research

outputs. All identifiable data will be stored securely on university servers or in locked cabinets, and no identifiable information will be included in publications or reports.

Are there any benefits in taking part?

While there are no immediate benefits for those people participating in the research, it is hoped that this research will lead to a better understanding of workplace bullying and ways it can be overcome.

What information will be collected and why is the collection of this information relevant for achieving the research objectives?

This project will collect audio-recorded (University USB microphone) interview data about your experiences of workplace bullying during O&G training. This may include discussion of sensitive personal experiences, which constitutes *special category data* because it relates to your working environment and potentially your wellbeing. This information is needed to understand the nature, impact, and patterns of bullying within O&G training to answer the research question: *What are O&G residents' experiences of workplace bullying?* The interview recording will be transcribed, and the transcript will be fully anonymised, with all names, roles, places, and any details that could identify you removed or generalised. Audio recordings, consent forms, and any other identifiable data will be stored securely on university servers and in locked cabinets on university sites, accessible only to the researcher and supervisor. Identifiable data will be destroyed once transcription and checking are complete. Anonymised interview data will be stored for up to 3 years after publication in accordance with University of Oxford policy. Only the researcher and supervisor will have access to the research data. No data will be transferred outside the UK, and no information will be shared with anyone else unless explicitly required by law. The anonymised data will be used solely for this project and will not be shared for future studies.

Will the research be published? Could I be identified from any publications or other research outputs?

The findings from this research will be written up in a master's dissertation submitted to the University of Oxford and may also be developed into academic publications or conference presentations. In all research outputs, you will not be identifiable, as all data will be anonymised and any details that could reveal your identity will be removed or altered. With your permission, I may use direct quotations from your interview; these will always be anonymised and will not include your name or any information that could identify you. A copy of the dissertation will be deposited online in the Oxford University Research Archive (ORA), where it will be publicly available to support future research.

Data Protection

The University of Oxford is the data controller with respect to your personal data, and as such will determine how your personal data is used in the research. The University will process your personal data for the purpose of the research outlined above. Research is a task that is performed in the public interest. Further information about your rights with respect to your personal data is available from the University's Information Compliance website at https://compliance.admin.ox.ac.uk/individual-rights.

Who has reviewed this research?

This research has received favourable opinion from a subcommittee of the University of Oxford Central University Research Ethics Committee.

Who do I contact if I have a concern about the research or I wish to complain?

If you have a concern about any aspect of this research, please contact myself as the primary researcher at ellie.manson@wolfson.ox.ac.uk or Nigel Fancourt as primary supervisor at nigel.fancourt@education.ox.ac.uk or Steve Thornton as clinical lead at steve.thornton@uhcw.nhs.uk. We will do our best to answer your query and acknowledge your concern within 10 working days with an indication of how it will be dealt with. If you remain unhappy or wish to make a formal complaint, please contact the University of Oxford Research Governance, Ethics & Assurance (RGEA) team at rgea.complaints@admin.ox.ac.uk or on +44 (0)1865 616480.

Further Information and Contact Details

If you would like to discuss the research with someone beforehand (or if you have questions afterwards), please contact:

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D)

Consent to take part in 'What are O&G residents' experiences of workplace bullying?'

Central University Research Ethics Committee (CUREC) reference: **AP02 / Ethics reference: Education (Educ) DREC - 2423295**

Purpose of Study: This study aims to explore experiences of bullying during O&G training, to identify recurring themes and potential strategies to prevent and address systemic bullying.

	Please initial each box if you agree with the statement
I confirm that I have read and understand the information sheet for the above research. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐
I understand that my participation is voluntary and that I am free to withdraw up until the end of the interview without giving reason.	☐
I understand who will have access to personal data provided, how the data will be stored and what will happen to the data at the end of the project.	☐
I understand the extent to which I could be identifiable, despite all possible efforts to maintain anonymity, from any publication of this study's findings.	☐

I consent to being audio recorded. ☐

I understand how audio recordings will be used in research outputs. ☐

Use of quotations: Please indicate your preference (select *one* option):
a) I do not wish to be quoted. ☐
b) I agree to the use of quotations in research outputs if I am not identifiable. ☐

I understand how to raise a concern or make a complaint. ☐

I agree to take part.[1] ☐

_____	dd / mm / yyyy	_____
Name of participant	Date	Signature

_____	dd / mm / yyyy	_____
Name of person taking consent	Date[2]	Signature

[1] I hereby assign to the researcher all copyright in my contribution for use in all work stemming from this project and future projects.

[2] To be signed and dated in the presence of the participant. Once this has been signed by both parties the participant should receive a copy of the signed and dated participant consent form. The original signed and dated consent form should be kept with the project's main documents, which must be kept in a secure location.

E)

What are O&G residents' experiences of workplace bullying?
PARTICIPANT QUESTION SHEET
Central University Research Ethics Committee Reference: AP02

1. Thinking back to your time in O&G training, how would you describe the general culture of the workplace, particularly in relation to how residents were treated?

2. How would you define workplace bullying in the context of O&G settings?

3. Can you describe any experiences of workplace bullying you encountered during your O&G training, and how these situations unfolded?

4. How, if at all, did these experiences impact your practice or learning?

F)

Education (Educ) DREC
15 Norham Gardens, Oxford, OX2 6PY

Applicant: Ellie Manson
Principal Investigator: Nigel Fancourt
Department: Education

Study title: What are O&G residents' experiences of workplace bullying?
(Version: 1.0)
Ethics reference: Education (Educ) DREC - 2423295

Dear Nigel Fancourt,
On behalf of the Committee, I confirm that the above research study described in the application and other supporting documentation submitted to the committee has been carefully considered by the Education (Educ) DREC in accordance with the University's regulations and policy for ethics approval of research involving human participants, human tissue and/or personal data. The opinion is as follows:

Opinion of Research Ethics Committee: Favourable Opinion
Subject to the following conditions:
Decision Date: 15 Dec 2025, 11:26
Opinion End Date: 1 Sep 2026

If favourable, insurance-provided indemnity arrangements will be in place between the decision date and opinion end date and you may now commence your study activities. Should you plan to continue the research beyond the end date above, it is your responsibility to ensure that you request, and receive, an extension (via amendment) from the committee for indemnity to remain in place. You may be required to provide a justification.
Please note the following:
Amendments: Should there be any subsequent changes to the reviewed study, applications for amendments can be made via the Oxford Ethics Application System (Worktribe Ethics).
Reports: Studies considered by OxTREC are expected to submit an *annual progress report* on each anniversary of study approval, until the study is completed. An end of study report is also required.
Audit: This study may be selected for audit at the discretion of the Research Governance, Ethics and Assurance Team.
Data safety: It is the responsibility of the PI to ensure that all data collected during the course of the study is stored and transferred safely and securely in accordance with University requirements. Further guidance and

advice are available from the Research Data Team. Additional information is available at https://researchsupport.web.ox.ac.uk/governance/ethics
Yours Sincerely

Education Ethics Officer

G)

Subject: Invitation to take part in research on O&G training experiences
Dear Colleague,
I am writing to invite you to take part in a research study exploring **experiences of workplace bullying during Obstetrics and Gynaecology training**.
You are being invited because **you are or have been a resident in O&G and now work within UHCW NHS Trust**. Participation involves a **one-to-one semi-structured interview**, lasting up to one hour (often shorter), conducted **in person on UHCW NHS Trust premises or via Microsoft Teams**, according to your preference.
Participation is **entirely voluntary**, and all data will be handled confidentially. Interviews will be audio-recorded with your consent and anonymised before analysis. You may withdraw at any time without giving a reason.
Please find attached a **Participant Information Sheet**, which provides full details about the project. If you would like to take part or have any questions, please contact me at:
Ellie Manson
Department of Education, University of Oxford
ellie.manson@wolfson.ox.ac.uk
Response link: O&G residents participation – Fill in form
Kind regards,
Ellie Manson