Inappropriate behaviours in a dental training environment: pilot of a UK-wide questionnaire

Gabriele Baniulyte,*[1] Neda Jajeh,[1] Sunmeet Kandhari,[1] Yen Ming Lin,[1] Stephen Magill,[1] Lucy Malcolm,[1] Bronagh McGuckin,[1] Elizabeth Morphet[1] and Christine A. Goodall[1]

Key points

The Inappropriate Behaviour in Dentistry Pilot Survey is the first of its kind in the UK.

Over two-thirds of respondents reported that inappropriate behaviour is an issue within UK dental training.

Several recommendations were suggested to reduce the prevalence of these behaviours and further research is required to determine true prevalence of this problem.

Abstract

Incivility and inappropriate behaviour in the workplace are topics of growing interest due to their impact on patient care and safety. Several surveys and campaigns have emerged highlighting the existence of a problem. However, the true scale is difficult to ascertain. The aim of this study is to determine the existence of inappropriate behaviours within the UK dental training environment.

An anonymous pilot questionnaire was distributed across multiple platforms reaching out to dental professionals within training environments, inviting responses between July 2022 and October 2022. A total of 215 responses were received. The vast majority (73.2%) felt that inappropriate behaviour is a problem within UK dental training. Senior colleagues were identified as perpetrators in 88% of responses. Most respondents (66%) reported feeling uncomfortable raising the issue, and when raised, 30% felt unsupported. Only 9% felt confident that action was taken after the issue was reported. Belittling was experienced and witnessed most commonly.

The feedback received reveals the existence of inappropriate behaviours within dental training environments. Qualitative feedback indicates that if left unaddressed, the impact of such behaviour may persist long-term. Further research is required to address this issue, improve dental training conditions and job satisfaction.

Introduction

Teamwork is embedded in all aspects and levels of healthcare and is fundamental to a safe patient journey. It impacts communication, decision-making, multidisciplinary working and ultimately, patient safety. Effective teamwork improves the performance and career satisfaction of staff, which leads to reduced patient complaints and a reduced hospital standardised mortality rate.[1]

Incivility at work has been defined as 'deviant behaviour with potential intent to cause harm to the target'.[2] It is important to consider this concept during complex workplace interactions, with frequent occurrence to allow for a positive and error-free outcome.[3] This is particularly true in the fields of dentistry, medicine and surgery, where repeated interactions occur between several groups of people in a very close environment in order to produce a safe outcome for the patient. Several campaigns have been launched around the world to highlight the issues of incivility at work, starting in the entertainment industry with the #MeToo movement, and more recently in medical and surgical fields, including the Surviving in Scrubs campaign,[4] #HammeritOut,[5] #LetsRemoveIt',[6] 'Operating with respect'[7] and Sexism in medicine.[8] The very existence of these campaigns is proof that incivility and inappropriate behaviour exist but the true scale of the problem is difficult to ascertain. The British Medical Association (BMA) published a review into workplace bullying and harassment of doctors, indicating some 22% of doctors have experienced these behaviours, with higher incidence for certain protected characteristics.[9]

The short- and long-term effects of incivility and inappropriate behaviour within a workplace range from reduced efficiency in juggling tasks to reduced cognitive ability and work quality. It can result in individuals taking it out on others, avoiding those responsible who are often their seniors, the people they should be able to approach for advice on patient care, or in some cases, staff leaving the profession.[10] As a team, it can reduce the willingness to help others therefore limiting the function of teamwork and shared care. A randomised trial was able to attribute over 50% increase in diagnostic and procedural errors to rudeness.[11] Additionally, there is emerging evidence that patient witnesses believe this type of behaviour will negatively impact their treatment.[12]

A recent systematic review identified high workload, patient safety concerns, communication issues and lack of support as

[1]Royal College of Physicians and Surgeons Glasgow, Dental Trainees' Committee, Glasgow, Scotland, UK.
*Correspondence to: Gabriele Baniulyte
Email address: Gabriele.baniulyte@nhs.net

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predictors for incivility within healthcare.[13] It is the opinion of the authors that due to the transient and rotational nature of training, dentists often have to find their feet in unfamiliar hospitals, community clinics and dental practices, while also learning new clinical and theoretical knowledge in order to care for patients. All of these factors may reduce the likelihood that a trainee would ask for support if inappropriate behaviours did occur.

The Royal College of Physicians and Surgeons Glasgow (RCPSG) established the Dental Trainees' Committee in 2021, with members from across the four UK nations and from undergraduate students to speciality trainees. The wellbeing subgroup was subsequently formed to focus on identifying, understanding and exploring issues affecting the wellbeing of dental trainees throughout the UK, as well as discussing and actioning initiatives for positive change. As a group of trainees, we have anecdotally observed that a substantial number of trainees have encountered instances of inappropriate behaviours. Consequently, our intention was to shine a light on this problem and initiate further investigation.

Therefore, we have piloted this questionnaire as a reporting exercise for the following reasons:

- To gather current information regarding inappropriate behaviour within the field of dentistry through an anonymous pilot questionnaire distributed nationally
- To provide opportunity for trainees to reflect on personal experience and voice concerns relating to wellbeing within their present and experienced training pathway
- To encourage discussion of the impact of certain behaviours on aspects of training including recruitment, progression and professional dynamics
- To strive for positive change and impact from the feedback and discussion of this survey, paving the way for further research to improve awareness and accountability.

Table 1 Summary of respondents' demographics

Sex (Answered: 214; skipped: 1)	Male	35% (n = 75)
	Female	63% (n = 134)
	Prefer not to say	2% (n = 5)
Country (Answered: 205; skipped: 10)	England	57% (n = 117)
	Northern Ireland	3% (n = 6)
	Scotland	36% (n = 73)
	Wales	4% (n = 9)
Age (Answered: 214; skipped: 1)	22–30	42% (n = 90)
	31–40	27% (n = 57)
	41–50	15% (n = 33)
	51–60	11% (n = 23)
	61–65	2% (n = 4)
	66–70	0.50% (n = 1)
	71+	3% (n = 6)
Training grade (Answered 297; skipped: 8)	Dental student	2% (n = 4)
	Foundation/vocational training)	7% (n = 14)
	DCT	15% (n = 32)
	SAS grade	16% (n = 33)
	Consultant	19% (n = 39)
	Nurse	0.50% (n = 1)
	Specialty registrar	26% (n = 53)
	Academic clinical fellowship	3% (n = 6)
	Other	12% (n = 25)

Methodology

Following a literature review on inappropriate behaviours in dental and medical training environments, a 14-question anonymous pilot questionnaire (SurveyMonkey, Momentive, CA, USA) was prepared by members of the RCSPG Dental Trainee Committee. It was reviewed by the senior members of the RCPSG dental faculty to ensure face validity. Questions (see online Supplementary Information) explored respondents' experiences of inappropriate behaviours within dentistry and the practice of raising concerns. While the survey was designed for ease of completion and collected tick-box information, it also provided space for free-text answers. As this was a pilot questionnaire with the primary aim of service evaluation and no identifiable information was recorded, ethical approval was deemed not necessary. At the start of the questionnaire, it was stated that by completing it, the participant gave consent to participate and to the use of anonymised data for reports and publications.

The survey was made available through an online link and distributed across several platforms using the RCSPG's email list, Twitter, Facebook and Instagram handles, targeting dental professionals who are currently or have been in the past involved in training their colleagues or being trained themselves, including consultants, speciality trainees, dental students and dental core trainees (DCTs). Other Royal College networks and dental faculties were also asked to share the link through their local networks. This voluntary and non-probability sampling was used in order to reach as many dental professionals in training environments as possible, employing a snowballing technique to reach the self-selecting population. The survey invited responses between July 2022 and October 2022, with consistent promotion on the aforementioned channels throughout to increase participation. As the survey specifically asked about experiences during training, consultants were asked to reflect on their time as trainees. Dental professionals with no recent experience in training environments were excluded from the study.

Data were collated by members of the RCPSG administration team and before sharing data with the trainee group for analysis, any person- or institution-specific identifiable information was redacted to ensure anonymity. Qualitative data were subject to descriptive analysis with

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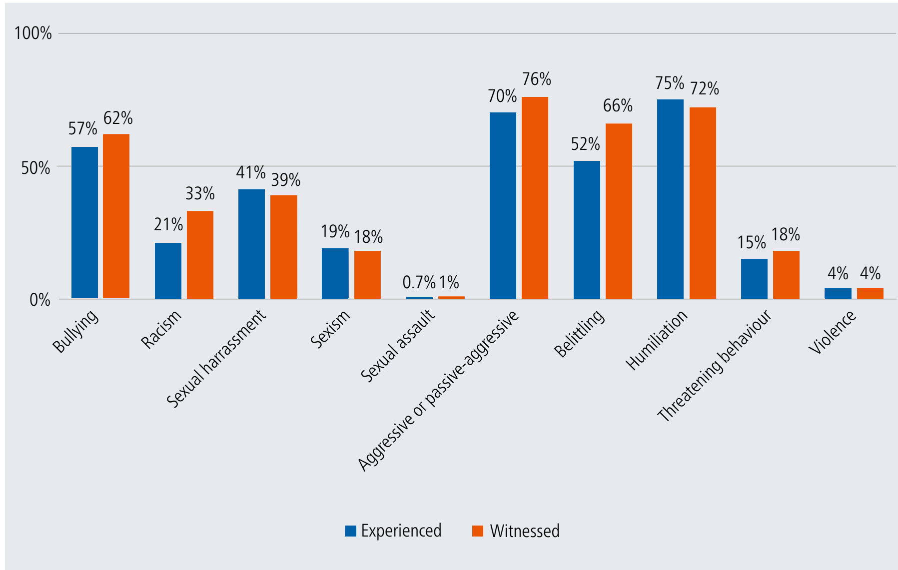
Fig. 1 Inappropriate behaviours experienced or witnessed as selected by all survey respondents



the help of NVivo software (QRS International) to extract themes from the free-text comments. All authors reviewed the free-text responses and agreed on the common themes identified.

Feedback from self-selecting respondents

Demographics

A total of 215 responses were received. The response rate was not quantifiable due to the distribution methods used (reaching an unknown number of recipients). There was notable variation in completion rate between the questions.

The distribution of respondents according to sex, geographical location, age and training grade is summarised in Table 1: 63% (n = 134) of respondents were women, 35% (n = 75) were men and the remainder 2% (n = 5) chose not to disclose their sex. Responses were received from clinicians of all ages, ranging from 22–71+ years old, with an unknown median, as an exact age was not asked.

The largest cohort 42% (n = 90) consisted of those aged between 22–30 years old. Most respondents chose England as their place of work (57%; n = 117), followed by Scotland (36%; n = 73), while a small number of responses was also obtained from Wales (4%; n = 9) and Northern Ireland (3%; n = 6).

Speciality trainees represented the largest group of respondents (26%; n = 53), followed by consultants (19%; n = 39), SAS (speciality and associate specialist grades) (16%; n = 33) and DCTs (15%, n=32). The remainder identified as either dental students (n = 4), dental foundation trainees (n = 14), nurse (n = 1), academic clinical fellows (n = 6) or 'other' (n = 25). The vast majority of respondents (73.2%; n = 112) expressed the view that inappropriate behaviour is an issue within UK dental training.

Experiencing and witnessing inappropriate behaviours during training

Questions regarding types of inappropriate behaviours were designed as 'select all that apply'. All types of inappropriate behaviours presented as options in the survey had been personally experienced by respondents (Fig. 1). Aggressive or passive-aggressive communication was the most personally experienced inappropriate behaviour, as selected by 75% (n = 105) of respondents, followed by belittling (70%; n = 98), bullying (57%; n = 80) and humiliation (52%; n = 73). Similar trends were also noted in inappropriate behaviours witnessed towards other colleagues. Experiencing or witnessing behaviours directly causing physical harm, sexual assault or violence were reported by 5% (n = 15) of all respondents, and it was noted in the free-text that acts of criminal offence were reported to the police.

In the open-ended sections, individual respondents highlighted instances of discrimination related to sexual orientation or homophobia. Additional comments addressed discrimination based on weight and experiences of gaslighting, as well as concerns regarding professional and training job security.

Source of inappropriate behaviour

An overwhelming majority (89%; n = 140) reported their senior colleagues as the perpetrators of the inappropriate behaviours, whether witnessed or experienced. Junior colleagues featured in 6% (n = 10) of responses and same-level trainees as 20% (n = 31). A notable 29% (n = 46) of responses identified another healthcare professional as the instigator of such behaviour. Multiple respondents (10%; n = 16) drew attention to instances of inappropriate behaviour involving non-clinical staff members and patients.

Raising the issue of experienced or witnessed inappropriate behaviour

The majority (69%; n = 109) of those who had experienced inappropriate behaviour felt uncomfortable escalating it, while only 11% (n = 18) of respondents felt comfortable. Neutral and not applicable responses were selected by 20% (n = 31). Similarly, individuals who had witnessed inappropriate behaviours towards their colleagues (66%; n = 104) felt uncomfortable about raising concerns. Only 18% (n = 28) felt comfortable in raising the issue of inappropriate behaviours. Some of the respondents felt neutral or selected not applicable (16%; n = 26).

Support for trainees reporting inappropriate behaviours

For those who had raised an issue (n = 136), there were multiple sources of support cited, including their educational supervisors (24%; n = 37), clinical supervisors (22%; n = 33) and training programme directors (22%; n = 34). A total of 21% (n = 32) of respondents selected 'other' and cited the following reporting mechanisms: clinical managers; senior colleagues, including consultants; clinical leads; medical/clinical directors; dean of a dental school; and the police.

Once an incident had been reported, 30% (n = 46) of respondents felt unsupported and 24% (n = 37) felt supported, with a further 10% (n = 15) of respondents feeling neutral and 37% (n = 57) selecting not applicable.

Only 9% (n = 14) of respondents who reported an issue felt confident that appropriate action was taken compared to 48% (n = 74) of respondents who did not feel confident in this.

Qualitative analysis of survey responses

Alongside the free-text options at the end of each question, the survey also asked for any further comments at the end of the survey. Themes identified in these free-text comments using thematic analysis included the below.

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Common inappropriate behaviours experienced

A frequently used phrase in the comments was 'belittling', usually in relation to the way a consultant or senior staff would treat trainees. This was a response option in our survey but the frequency of its use in free-text responses perhaps indicates the prevalence with which this behaviour had been encountered. Similarly, racism, bullying and homophobia were mentioned in several free-text responses. Exclusion and comments on physical appearance were mentioned by a small number:

- 'I've seen bullying and harassment disguised as "helpful feedback"'
- 'Often see belittling behaviour from consultants to DCT/staff'.

Lack of support

Numerous respondents implied that there was a lack of support to trainees when issues were raised and this is reflected in the qualitative data. Dismissing concerns, covering up and lack of change when issues are raised were mentioned, alongside a lack of meaningful engagement with trainees' concerns or attempts to resolve any issue generating the feeling of being unsupported. A number of responses highlighted that at times there is no completely independent person or body to whom to raise concerns:

- '[It is] challenging to raise concerns when your educational supervisor is within the department and may be the person carrying out the inappropriate behaviour'.

Impact on career

Several respondents expressed the belief that raising concerns did, or could have had, a detrimental effect on their training:

- 'Those who do try to raise these issues are often ignored, ostracised [...] disadvantaged in some ways...'
- 'I was worried dentistry is such a small world that I would come to regret it'
- 'Sometimes you consider the risk and benefit of bringing it up [...] but for career progression the risk normally just isn't worth it'.

Isolated incidents

A small number of concerns raised in the comments by respondents indicated an urgent need for change in the working environment at one unit or in relation to one individual perpetrator. It was concerning to potentially unearth a culture of inappropriate behaviour within any dental training unit that was allowed to progress unchecked. However, it was, in some ways, reassuring that these incidents seemed to be isolated:

- 'It only takes one aggressive bully consultant to ruin a trainee's experience of dental training'
- 'I have witnessed inappropriate behaviour during training. However, these have been isolated incidents linked to specific individuals and I would not want my response to be generalised to all'.

Discussion

The Inappropriate Behaviour in Dentistry Pilot Survey is the first of its kind for dental trainees of all levels, allowing exploration of the culture of working environments in relation to trainee wellbeing. This study reviews the impact of inappropriate behaviours affecting staff from a wide demographic, including responses from all four nations, different age groups and stage of training. The findings align with a recent BMA study on the impact of bullying on SAS doctors in the wider healthcare professions.[9]

The majority of responses supported our initial suspicion that this problem exists. Clinicians at all levels, from students to consultants, enthusiastically participated in the survey, indicating a widespread recognition of the issue and a desire for change. However, it is important to consider that some of the reported incidents may be historic.

All forms of inappropriate behaviour within a clinical environment are unacceptable and can lead to issues such as adverse patient outcomes, retention, productivity, absenteeism, ill health and suicidal ideation.[14,15] The most commonly reported behaviours in this study were belittling, humiliation, aggressive or passive-aggressive behaviours and bullying. Physically inappropriate behaviours including violence, sexual violence and sexual assault were reported less frequently, and some free-text responses noted that experienced physical behaviours were reported to the authorities.

Most of the respondents who had reported concerns over inappropriate behaviours reported escalating concerns to senior staff, including supervisors and training directors. This describes the current standard pathway trainees use. However, as evidenced in the feedback, most felt unsupported in doing so. The lack of an independent figure to disclose concerns to diminished individuals' faith in the reporting process. In addition, respondents suggested that raising concerns may have, in some capacity, a detrimental impact on their careers. Dental trainees face fierce competitive entry to training at all levels. There is no run-through training in dentistry at present; therefore, trainees could feel that reporting concerns may impact on their ability to progress.

There are several possible solutions to improve reporting and to give trainees more confidence in escalating concerns. Trust-endorsed Freedom to Speak Up Guardians aim to ensure action is taken where needed when an issue is brought up.[16] Another option may be the creation of peer support networks, where concerns can be discussed confidentially before reporting, to explore the best options for doing so.[17] Bystander training is also an important way to empower trainees to take action if witnessing inappropriate behaviours.

Most perpetrators involved in the reported scenarios were senior members of staff, further impacting the ability of junior trainees to escalate and overcome issues successfully. This may raise the question of how someone's own experience of training may influence their use of inappropriate behaviours. Progression through training requires involvement in teaching and training junior colleagues, a role which may not come naturally to many. Their own experience during early training years may shape a clinician's view on what constitutes successful teaching/training methods, with some inappropriate behaviours, such as humiliation and belittling, becoming normalised. Undertaking training in postgraduate medical education may enable trainers to improve training experiences.

Additionally, training in human factors and non-technical skills can also provide an invaluable insight through scenario-based experience into the development and impact of inappropriate behaviours.[18] Furthermore, our committee has given thought to the benefits of multisource feedback as a tool to flag concerns. We suggest that individuals involved in training should consider using it for their own continued professional and personal development, crucially including trainee feedback, on an annual basis. Recruitment and retention in UK dentistry is an existing challenge, as highlighted by the recent scoping review.[19] Therefore, it is imperative to prioritise a positive training experience by offering support and fostering a safe and nurturing environment encouraging career progression.

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Several study limitations were noted. Firstly, due to the pilot questionnaire being shared over a number of different pathways and social media platforms, it is challenging to quantify the overall response rate and number of potential respondents reached. Respondents were also able to skip questions, resulting in a different completion rate for each question. Secondly, participant and recall bias should be considered. It is likely that trainees were more motivated to take part in the survey if they had been involved in inappropriate situations rather than if they have never experienced or witnessed them. Thirdly, we were not able to establish the reliability or the validity of the survey because of the sensitive nature of the topic and the importance of retaining anonymity which allowed respondents to be candid. Additionally, as this was a pilot survey, the results are not representative or generalisable. These issues should be considered in any future research on the topic. Lastly, a further limitation of this pilot questionnaire is that individuals may interpret comments differently. For one person, a comment might be seen as constructive feedback, while for another, it might be considered harassment. Since this study lacks contextual details and additional data, its scope is limited to reporting the subjective experiences of the specific participants who chose to take part. Therefore, it becomes evident that the nature of such behaviours is inherently abstract and lacks concrete delineation.

This survey did not ask respondents to specify which speciality they were currently working in or where any inappropriate behaviour was encountered. However, it was noted that a larger volume of responses volunteered that they related to training experiences within oral and maxillofacial surgery (OMFS) departments. Although this may appear to suggest that the majority of inappropriate behaviours occur in OMFS departments, it is important to consider that most DCTs were likely to have had experience within OMFS due to the large number of OMFS posts available for training. It should therefore not be concluded that these behaviours predominantly occur within in OMFS environments, or indeed any speciality or department:

- 'Dental training is largely welcoming and friendly; however, you will, of course, stumble across an individual who lets the side down'.

Conclusion

The feedback has captured information regarding the existence of unacceptable behaviour within dental training environments. We are aware this is not an issue exclusive to dental training and cannot be generalised to all institutions, but part of a bigger problem within workplaces in all sectors. We would therefore implore every professional to be mindful of the pressures faced by colleagues, including dental trainees, who are often placed in unfamiliar environments, sometimes with limited experience. We urge consultants and senior staff members to act on any witnessed inappropriate behaviour. Further research is needed into the origins and true scale of the problems of both incivility and inappropriate behaviour within dental training to eliminate it from the dental training environment.

Ethics declaration

The authors declare no conflicts of interest.

As this was a pilot questionnaire with the primary aim of service evaluation and no identifiable information was recorded, ethical approval was deemed not necessary. At the start of the questionnaire, it was stated that by completing it, the participant gave consent to participate and to the use of anonymised data for reports and publications.

Author contributions

Gabriele Baniulyte, Neda Jajeh, Sunmeet Kandhari, Yen Ming Lin, Stephen Magill, Lucy Malcolm, Bronagh McGuckin, Elizabeth Morphet and Christine A. Goodall have all contributed to the creation and execution of this survey and all authors contributed to the write-up and final draft of this manuscript.

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References

1. Civility Saves Lives. Homepage. Available at https://www.civilitysaveslives.com/ (accessed March 2023).
2. Andersson L M, Pearson C M. Tit for Tat? The Spiraling Effect of Incivility in the Workplace. *Academy Manage Rev* 1999; **24:** 452–471.
3. Di Fabio A, Gori A. Assessing Workplace Relational Civility (WRC) with a New Multidimensional 'Mirror' Measure. *Front Psychol* 2016; **7:** 890.
4. Surviving in scrubs. Homepage. Available at https://survivinginscrubsorg.wordpress.com/ (accessed March 2023).
5. Rimmer A. Orthopaedic trainees launch anti-bullying programme. *BMJ* 2017; **356:** 398.
6. The Royal College of Physicians and Surgeons Edinburgh. Bullying and Undermining Campaign – Let's Remove it. 2017. Available at https://www.rcsed.ac.uk/news-public-affairs/news/2017/june/bullying-and-undermining-campaign-let-s-remove-it (accessed March 2023).
7. Royal Australasian College of Surgeons. Operating with respect. Available at https://www.surgeons.org/en/Education/Professional-Development/Operating-with-Respect#:~:text=It%20is%20designed%20to%20deliver,and%20ultimately%20improves%20surgical%20care. (accessed November 2023).
8. British Medical Association. Sexism in medicine. 2021. Available at https://www.bma.org.uk/media/4487/sexism-in-medicine-bma-report.pdf (accessed March 2023).
9. British Medical Association. Workplace bullying and harassment of doctors: A review of recent research. 2017. Available at https://www.yorksandhumberdeanery.nhs.uk/sites/default/files/bullying_and_harassment_research_review_v7_web.pdf (accessed March 2023).
10. Porath C, Pearson C. The price of incivility. *Harv Bus Rev* 2013; **91:** 114–146.
11. Riskin A, Erez A, Foulk T A *et al.* The Impact of Rudeness on Medical Team Performance: A Randomized Trial. *Pediatrics* 2015; **136:** 487–495.
12. Vargas E A, Mahalingam R, Marshall R A. Witnessed Incivility and Perceptions of Patients and Visitors in Hospitals. *J Patient Exp* 2021; DOI: 10.1177/23743735211028092.
13. Keller S, Yule S, Zagarese V, Parker S H. Predictors and triggers of incivility within healthcare teams: a systematic review of the literature. *BMJ Open* 2020; DOI: 10.1136/bmjopen-2019-035471.
14. Layne D M, Nemeth L S, Mueller M, Martin M. Negative Behaviours among Healthcare Professionals: Relationship with Patient Safety Culture. *Healthcare (Basel)* 2019; **7:** 23.
15. Bamberger E, Bamberger P. Unacceptable behaviours between healthcare workers: just the tip of the patient safety iceberg. *BMJ Qual Saf* 2022; **31:** 638–641.
16. National Guardian's Office. About us. Available at https://nationalguardian.org.uk/about-us/ (accessed March 2023).
17. Royal College of Physicians and Surgeons Edinburgh. Protecting Yourself, Protecting Your Colleagues. Available at https://www.rcsed.ac.uk/professional-support-development-resources/anti-bullying-and-undermining-campaign/protecting-yourself-protecting-your-colleagues (accessed March 2023).
18. Casali G, Lock G, Novoa N M. Teaching non-technical skills: the patient centered approach. *J Thorac Dis* 2021; **13:** 2044–2053.
19. Evans D, Burns L, Mills I, Bryce M, Hanks S. Recruitment and retention in dentistry in the UK: a scoping review to explore the challenges across the UK, with a particular interest in rural and coastal areas. *Br Dent J* 2023; DOI: 10.1038/s41415-022-5406-0.

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