sent through the post. If this screening is not available the commissioners of sexual health services should be made aware of this potentially avoidable harm.

Finally, we need to communicate better with women so that those at risk can perceive it and avail themselves of services. The challenge is not just in increasing knowledge. This can be done effectively with information campaigns.[8 9] It also lies in appropriate education that enables women to be aware of the possible risks of sexual behaviour and the ways to reduce those risks.

In short, hormonal emergency contraception has become even easier, but to deliver a holistic sexual health service we still have challenges to meet.

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Workplace bullying

The silent epidemic

See Career focus

Those who can, do; those who can't, bully.

Tim Field

Morbidity patterns from general practice worldwide highlight the high prevalence of mental health problems, the commonest being depression, anxiety, and sleep disturbance. Many of the sufferers admit to stress at work, and some of them are casualties of workplace bullying, defined as persistent, offensive, abusive, intimidating, malicious, or insulting behaviour; abuse of power; or unfair penal sanctions. These make the recipient feel upset, threatened, humiliated, or vulnerable, undermine their self confidence and may cause them to suffer stress.[1] Rayner and Hoelt describe five categories of bullying behaviour—threats to professional status, threats to personal standing, isolation, overwork, and destabilisation.[2]

A deadly combination of economic rationalism, increasing competition, "downsizing," and the current fashion for tough, dynamic, "macho" management styles have created a culture in which bullying can thrive, producing "toxic" workplaces.[3] Such workplaces perpetuate dysfunction, fear, shame, and embarrassment, intimidating those who dare to speak out and nurturing a silent epidemic. Various studies point to an emerging global phenomenon with a growing evidence base particularly from Scandinavia,[4] where Sweden and Norway are the only European countries with legislation specific to bullying.

Workplace bullying has been estimated to affect up to 50% of the United Kingdom's workforce at some time in their working lives,[5] with annual prevalences of up to 38%, and is becoming increasingly identified as a major occupational stressor.[6] In the United Kingdom costs have been estimated at £2-30bn ($3-48bn; €3-44bn) per annum,[6] although research indicates figures closer to the lower end of the range.

Of particular concern is the growing evidence of bullying among healthcare workers. A 1996 questionnaire survey of 1100 employees of an NHS community trust found 38% reported being subjected to bullying in the workplace in the previous year, and 42% had witnessed the bullying of others.[7] Staff who had been bullied had lower levels of job satisfaction and higher levels of job induced stress, depression, anxiety, and intention to leave. Similar rates were found in a recent survey of 1000 junior hospital doctors in the UK.[8]

The obvious question remains, "What can be done?" As practitioners we should be more aware of the possibility that workplace bullying may be contributing to the stress with which many of our patients present. Questions like "How are things at work?" should also become part of routine inquiry in patients presenting with anxiety, depression, or sleep disturbance—providing an opportunity to raise bullying. Bullying can also manifest itself in cognitive effects such as concentration problems, insecurity, and lack of initiative.[9]

When identified, we should be supporting and encouraging our patients in combating bullying. As general practitioners we should adopt an advocacy role for our patients and offer appropriate intervention after obtaining explicit informed consent. To be most effective in this role we need to be familiar with the issues and to know where to seek appropriate advice and help—much practical information and advice on identifying, preventing, and combating bullying is available on the internet and in books,[3 6] and can be adapted for handouts for patients' education. In addition, occupational health doctors and nurses can be helpful sources

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of advice and support, but effective communication between general practitioners and occupational doctors is unfortunately uncommon.[10] A number of interventions to change workplace factors that have been shown to reduce psychological ill health include counselling, training to manage stress, cognitive behavioural therapy, and workplace support programmes.

The medical profession is under ever increasing public scrutiny, and levels of accountability continue to rise. However, statistics from the UK national workplace bullying advice line show that 20% of cases are from the education sector, 12% from health care, 10% from social services, and 6-8% from the voluntary sector.[6] We need to set our own house in order and should all be striving to foster working environments free of bullies, whether in our hospitals, practices, professional organisations, or colleges.

Those of us involved in teaching medical students and registrars should be mindful of the powerful effects of role modelling on impressionable learners. The authors of a survey of medical students in the United States, along with others, believe that the use of aversive methods to make students learn to behave is likely to foster insensitive and punitive behaviours that are passed down from the teacher to learner, a transgenerational legacy that leads to future mistreatment of others by those who themselves have been mistreated. This undesirable result is compounded when these behaviours are adopted and directed towards patients and colleagues.[11] If we are to avoid perpetuating the harrowing experiences of bullying recently described in the *BMJ* by a surgical trainee in the NHS,[12] we need to lead by example.

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Hospital mortality league tables

Question what they tell you—and how useful they are

Last week (6 April) the *Sunday Times* published the latest annual assessments of hospital performance compiled by the Dr Foster organisation. Dr Foster claims to provide the "only authoritative and independent guides to UK health services in the public and private sectors" and seeks to "empower consumers and their doctors to make the best possible choices."[1] Dr Foster has brought together a wealth of information, including equipment and services available at each hospital and how the hospital performs on waiting lists and complaints, but its hospital mortality figures will arouse the most interest. Many in the NHS and elsewhere will be asking themselves how they should respond to these data.

Four main questions need a response. Firstly, what do the data actually mean? A hospital does much more than treat inpatients. Over the past decade the scope and nature of ambulatory care provided in hospitals has changed enormously, not only in surgery but also in other specialties such as oncology, where increasingly sophisticated treatments involve a complex mix of inpatient and outpatient episodes.[w1] Moreover, there is good evidence that as the length of the average hospital inpatient episode falls, an increasing proportion of deaths occur outside the hospital.[2] Consequently, a measure of outcome looking only at inpatients is a highly selective view of the overall picture.

Secondly, are the results a valid measure of what they purport to be? Compared with previous years[w2] Dr Foster has done much to enhance the quality of the data used since it published its first guide. It has changed the way it deals with in-hospital transfers and excludes people who are recorded more than once as having died. Of course, this means that rankings this year are not comparable with those in previous years—so all changes in rankings need to be interpreted with caution. But the Dr Foster method cannot avoid the probably insoluble problem arising from the continuing use of finished consultant episodes—the NHS's measure of hospital activity.[w3] Since a patient's stay in hospital might include several finished consultant episodes these need conversion to hospital spells, and assumptions have to be made about which episode's main diagnosis to use**.** This method could be improved if supported by an audit of case notes, but this would need to be led by clinicians. In addition, the meaning of a hospital spell for someone suffering multiple complications of a chronic disease, possibly requiring several admissions over the course of a year, remains unclear.

Extra references appear on bmj.com

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