WELLBEING & WORKPLACE DIGNITY | MODULE 04

Difficult workplace relationships

Distinguish disagreement, poor communication, incivility and persistent undermining, then choose a response that protects safety and dignity.

✓ 16 min reading

✓ Full teaching, practical next steps and reflection

✓ Six practice questions with answers and explanations

✓ Complete source list and jurisdiction notes

Prepared for SAS, locally employed and other UK doctors

Author: Dr N Aziz

Using this module

Independent education	This is general professional information, not individual clinical, legal, employment, immigration, regulatory, tax or pensions advice. Current official instructions and the circumstances of the individual case remain controlling. Practice scores do not establish professional competence or accreditation.

The short answer

Not every conflict is bullying, but behaviour does not need a legal label before it can be addressed. Describe what occurred, its pattern and impact; assess power and safety; then choose direct conversation, supported resolution or a formal route.

Three next actions

- Describe the behaviour in neutral, specific language.
- Decide whether a direct conversation is safe and likely to help.
- Ask for support early if there is repetition, power imbalance, retaliation or effect on patient care.

Learning objectives

- Distinguish ordinary disagreement from harmful behaviour.
- Use a structured conversation where appropriate.
- Recognise when informal resolution is unsafe or insufficient.

Conflict, incivility and undermining

Professional disagreement can be legitimate and sometimes essential for safe care. It becomes harmful when the method is humiliating, threatening, discriminatory, persistently dismissive or designed to exclude. Incivility may include interruptions, sarcasm, eye-rolling, ignoring contributions or discourteous messages. Undermining may involve repeatedly questioning competence without basis, withholding necessary information, moving expectations, taking credit or excluding someone from work they need to perform their role.

One serious incident can matter; repetition is not always required. Pattern nevertheless helps explain cumulative harm. Consider behaviour, context, frequency, audience, power, impact, response when challenged and whether others are treated differently. Avoid beginning with a contest over labels. A factual account allows the organisation to examine what happened.

Prepare a direct conversation

Where safe, clarify your purpose: to stop a behaviour, understand a misunderstanding, agree a working method or protect a clinical process. Choose a private setting and describe one or two examples. Use a simple structure: when this happened, the effect was this, and I need this to change. Invite response without surrendering the boundary.

For example: 'When my plan was described as ridiculous in front of the ward team, it made clinical discussion difficult and undermined confidence in the agreed plan. If you disagree, please raise the clinical concern without personal language.' Do not send a long accusatory email while distressed. Draft, pause, obtain advice and decide whether a conversation or formal record is more appropriate.

When not to meet alone

A direct conversation may be unsuitable where there has been violence, threat, sexual behaviour, severe intimidation, a marked power imbalance, retaliation, active investigation or a reasonable fear for safety. It may also be unhelpful when the person has already denied repeated clear examples or when policy requires formal handling. Seek union, HR, dignity-at-work, speaking-up or managerial advice before arranging contact.

Mediation is voluntary and aims to help parties find a workable resolution; it is not an investigation and does not decide whether discrimination occurred. It may help misunderstanding or relationship breakdown, but should not be used to pressure a person into confronting alleged abuse or to avoid examining serious allegations. Ask what the process records, what remains confidential and whether you can obtain advice before agreeing.

Protect the clinical work

Relationship difficulty can affect handover, escalation and willingness to ask for help. Make clinical communication explicit and use recognised channels. Confirm important decisions, responsibilities and escalation in the patient record or approved operational system as appropriate. Do not use the clinical record to document an employment dispute.

If another person's conduct creates immediate patient risk, raise that risk through clinical governance even while the relationship issue is addressed separately. A request for respectful behaviour should never depend on accepting unsafe ambiguity in patient care.

Seek support without creating a rumour network

Choose people by role: a supervisor for work and development, a SAS Advocate for navigation and patterns, a union for employment advice, occupational health or a clinician for health, and a speaking-up route for wider safety or organisational concern. A trusted colleague may help you think, but repeated informal retelling can breach confidentiality and entrench camps.

Tell supporters what you need: listening, help organising facts, attendance at a meeting, policy interpretation, representation or clinical care. Ask what notes they keep and whether they may have to share information. This is particularly important if the person also holds a management, educational or investigative role.

Review whether the response worked

An apology can be meaningful, but resolution should be judged by subsequent behaviour and restored safety. Agree practical changes and a review point. If the conduct continues, add the new event to the chronology and reconsider the route. The failure of an informal attempt does not mean the original concern lacked merit.

Watch for retaliation, isolation, adverse rota changes, removal of opportunity or disproportionate scrutiny after a concern is raised. Obtain advice promptly if this occurs. In discrimination law, less favourable treatment because someone made or supported a protected complaint may amount to victimisation, but only an appropriate adviser or tribunal can determine a legal claim.

Worked example: disagreement becoming personal

During several meetings, a doctor’s clinical suggestions are interrupted and described as obstructive. The doctor first checks the minutes and speaks privately with the chair, giving two precise examples and asking that disagreements be summarised and decisions allocated fairly. The chair agrees ground rules and a review after two meetings.

When the same behaviour recurs and a decision is withheld from the doctor’s team, the doctor updates the chronology and seeks advice. The earlier informal attempt is not treated as failure; it demonstrates the requested change, the opportunity provided and the continuing effect on work.

Questions before a direct conversation

Ask whether you feel physically and professionally safe, whether the person controls your employment or assessment, whether there is a serious allegation, whether evidence could be lost, what outcome you want and whether a supporter or facilitated process would be more appropriate.

Plan a stopping point. If the discussion becomes threatening, discriminatory or clinically unsafe, end it calmly, make a factual record and obtain support. A direct conversation is an option, not a test of courage.

Common mistake

Avoid this	Trying to prove that a person is 'a bully' can distract from demonstrating the conduct, pattern, impact and remedy required.

Pause and reflect

What outcome do you need from the relationship - explanation, changed behaviour, protection, investigation or a different way of working?

Takeaways

- Address observable conduct rather than diagnosing motive or character.
- Informal resolution depends on safety, consent and seriousness.
- Keep clinical governance and employment concerns connected but recorded in the correct systems.

Knowledge check

Choose one best answer. These practice questions support reflection; they do not assess a real case or confer accreditation. Answer positions match the browser edition.

1. A colleague robustly disagrees with a treatment plan using respectful clinical reasons. Is that bullying?

A. Only if the colleague is senior

B. Only if the plan changes

C. Always

D. Not on those facts alone

2. Which wording is most useful in a direct conversation?

A. When you used that phrase in the meeting, it interrupted discussion; I need disagreement expressed without personal language

B. Everyone hates your behaviour

C. You always do this

D. You are toxic

3. When is mediation least suitable?

A. Both people freely agree

B. Both want a future working agreement

C. There is severe intimidation and a major power imbalance

D. A mutual misunderstanding

4. Where should an employment dispute be recorded?

A. In another patient's notes

B. In a public social-media post

C. In the patient's clinical record

D. In appropriate employment or organisational records

5. What is a useful question when approaching a supporter?

A. Will you promise nobody will ever know?

B. Will you contact everyone involved immediately?

C. Can you decide the case today?

D. What records do you keep and what are the limits of confidentiality?

6. How should an informal resolution be assessed?

A. By whether no notes were kept

B. By whether the concern was withdrawn

C. By later behaviour and restored safety

D. By whether an apology was offered

Answers and explanations

1. D — Not on those facts alone

Legitimate respectful disagreement is not itself bullying.

Review the distinction between disagreement and harmful conduct.

2. A — When you used that phrase in the meeting, it interrupted discussion; I need disagreement expressed without personal language

Specific behaviour, impact and requested change are clearer and less accusatory.

Review the conversation structure.

3. C — There is severe intimidation and a major power imbalance

Mediation should not be used to pressure someone into confronting alleged abuse or replace necessary investigation.

Revisit the limitations of mediation.

4. D — In appropriate employment or organisational records

Clinical records must remain focused on patient care.

Review separation of clinical and employment records.

5. D — What records do you keep and what are the limits of confidentiality?

Understanding role and confidentiality prevents mistaken expectations.

Review role-based support.

6. C — By later behaviour and restored safety

Sustained behaviour change and safe work are the meaningful outcomes.

Review how to evaluate resolution.

Official and professional sources

Confirm the current source version and applicable nation, contract, scheme or specialty. A source list is not a statement that every rule applies to every reader.

Good medical practice 2024
UK · https://www.gmc-uk.org/cdn/documents/good-medical-practice-2024---english_pdf-102607294.pdf

Acas: Bullying at work
Great Britain · https://www.acas.org.uk/bullying-at-work

Acas Code of Practice on disciplinary and grievance procedures
Great Britain · https://www.acas.org.uk/acas-code-of-practice-on-disciplinary-and-grievance-procedures/html

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