Workplace Bullying in Surgery

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“If you cannot measure it, you cannot improve it.” Lord Kelvin [1824–1907].

This environmental scan of workplace bullying in surgery although from Australia [1] could well be from most countries. Other reports cited in this article confirm similar rates of bullying in other countries and institutions. With the negative impact of bullying and other hostile workplace behavior on the surgeon, the patient, and the institution, data by which to measure improvement are important. Fortuitously, the data in this paper were obtained before the National Parliamentary inquiry into workplace bullying in Australia was conducted. As a result of that report, in January 2014, new anti-bullying laws went into effect. Also as a result of that report and other negative publicity regarding bullying in surgery, the Royal Australasian College of Surgeons commissioned an Expert Advisory Group to assist in clarifying and resolving the issue. The data in this paper will serve as a baseline against which progress can be measured and strategies can be assessed for success. The tools and methodology reported will be useful in this measurement. Bringing attention and definition to the problem should lead to improvement even if just by the Hawthorne effect.

Reading the list of 22 negative work place behaviors [Negative Acts Questionnaire-Revised, Einararen S, 2009] remind us that there is a spectrum of behaviors, i.e., a “slippery slope” into bullying. Each of these negative behaviors offers an opportunity for assessment and potential for intervention/remediation. This list is an excellent tool for scanning the workplace as it gives granular data

rather than just a global assessment. Such specific data should allow better development of strategies for improvement. The use of this list of negative behaviors which are to be avoided could be placed in administrative manuals and used in performance evaluation. Everyone should read the list.

The surgical field by its nature presents numerous situations where immediate action and the potential for adverse outcomes are exceedingly common. Intense scrutiny and rigorous criticism have always been and should be part of surgical training. Charles Bosk’s classic book on surgical training, “Forgive and Remember: Managing Medical Failure” which was originally published in 1979 then updated in 2003, describes the training of surgeons and the variable ways that poor outcomes are addressed, frequently arbitrary, and often abusive. The book should be a requirement of all surgeons involved in surgical training.

In the 50 years since I began my surgical training, although I have seen a dramatic reduction in the magnitude and extent of bullying and frank physical abuse, much still exists. Some surgeons believe that such rigorous criticism is essential to the development of sound surgeons. I know of no data to prove that hypothesis. Yet, I would not want to remove intense scrutiny of behavior and rigorous evaluation of adverse outcomes and near misses from routine practice in the surgical workplace. The method does not need to be brutalizing, bullying, and publicly humiliating. Routine processes for conducting reviews, assessing behaviors, and delivering critiques can avoid this. Ken Blanchard’s book “The One Minute Manager” originally published in 1982 updated in 2015 gives sound advice on how to give feedback. Evaluating instances of bad behavior requires time and careful thought. Often bad behavior is in response to a systems failure that has stressed the individual beyond their normal tolerance. Making the system

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change is what is needed not just a reprimand for the bully. Debriefings after adverse incidents can identify necessary changes.

Changes in the system which have improved safety and improved training such as skills labs, simulation, team training, protocols for treatment, and assignment of roles and responsibilities during critical times have steadily created an improved environment. Assessing other methods which identify situations where bullying occurs to see if patterns emerge that can be modified should be possible. Process improvement techniques should be applied to this problem as it has been to others.

This manuscript reports the incidence while raising many important questions. We need to know more about the identity and motivation of the bully and those bullied. What was the role of the administrators who were identified as bullies? Why were women and trainees bullied more often? Are they perceived as less powerful and why? Who bullies who? What about the bystanders who never confront the bully or report the behavior? Why is the bullying behavior not reported and even worse why is it tolerated?

What are the most accepted and successful reporting systems? All these are fruitful questions for further study.

I must however warn about creating a solution that just gets rid of the bully. Each individual in the healthcare system requires an enormous investment of time and money. We cannot afford to lose a single person unnecessarily. We need to identify ways to modify the behavior of the bully or modify the environment so that it does not illicit the bad behavior. The culture which has not only allowed but perhaps even supported this bad behavior must change yet preserve the scrutiny which assures quality. To create these changes, one must have people who have the moral courage to work with the bullies and challenge the system that has allowed this behavior.

Reference

1. Saw R, Ling M, Young CJ, et al (2016) Workplace bullying in surgery. *World J. Surgery* (in press)