

# Bullying in Surgery

Catherine Ferguson

*“To bully is to threaten, oppress or tease, either physically or morally, and can include: public humiliation, persistent criticism, personal insult, professionally undermining a person’s professional ability, consistently undervaluing effort and abuse of power. Bullying is not necessarily face-to-face; it may be by written communication, e-mail or telephone.”<sup>1</sup>*

This statement is taken from the Royal Australasian College of Surgeons (RACS) handbook on Bullying and Harassment, which was published in 2014.

Workplace NZ defines bullying as “repeated and unreasonable behavior directed towards a worker or a group of workers that creates a risk to health and safety.”

The recent work commissioned by RACS, and reinforced by New Zealand surveys of both resident doctors and medical students, has brought the issue of bullying in medicine into sharp focus over the past few months. However, this is by no means a recent phenomenon, and indeed *The New Zealand Medical Journal* and the *NZMJ Digest* have published on workplace bullying in 2004 and 2008.<sup>2,3</sup> A quick review of the international literature cites bullying in surgery all over the world, with recognition of the issues extending back to at least the 1990s.<sup>4-6</sup> In the past, this has been termed as ‘uncivil behavior’ and ‘disruptive behavior’, but it is time to accept that this is, quite simply, bullying.

The RACS Expert Advisory Group (EAG) review found that not only was bullying prevalent in surgery, but also that it is an ongoing problem, experienced at all levels in surgery, and that the consequences are far reaching. As well as surveying fellows, trainees and international medical graduates, personal stories were collected and online discussion forums provided a vehicle for honest exchanges and some very thoughtful comments. Some of the information shared was deeply disturbing and

distressing, and those who responded are to be commended for their bravery in sharing their stories.

Many respondents talked about the concept of bullying as a ‘rite of passage’ and a mechanism to ‘toughen-up’ young surgeons for the life ahead. Indeed, some RACS trainees surveyed acknowledged that bullying occurs, but see it as an inevitable part of surgical training. However, most survey respondents reported that far from ‘building resilience’ for the stressful life of a surgeon, bullying behavior has resulted in depression, feelings of inadequacy, suicidal ideation and exiting from surgery altogether. Many young doctors have decided against pursuing a career in surgery because of the behaviors they have witnessed.

It is well recognised that bullying in the workplace leads to poor performance, anxiety and absenteeism. It creates a poor learning environment, where trainees suffer from a lack in confidence and insecurity in their clinical skills. Pfifferling<sup>7</sup> reported in 1999 that bullying results in withholding information for fear of being bullied or criticised, not asking for help, withholding suggestions, reduction in self-esteem, increased staff turnover, blaming others and dysfunctional teams.

For decades, medical training—and surgery in particular—has adopted the apprenticeship model of teaching, and this has been successful in producing surgeons with high levels of medical knowledge and technical expertise. However, not only do our young surgeons learn their surgical

craft, but also they learn that bullying and disruptive behavior are condoned—even valued and accepted—as ‘normal’. It is a sad fact that many of us have become desensitised to poor behavior, to the extent that it is no longer recognised as wrong. Perpetrators are not taken to task for their actions, and colleagues and employers stand by and watch. It is little wonder that we see these poor behaviors being repeated from generation to generation of our surgeons.

Medical expertise and technical expertise are only two of the nine RACS competencies, which also include; professionalism and ethics, communication, collaboration and teamwork, advocacy as well as judgment, clinical decision making, scholarship and teaching, and management and leadership. Until now, traditional surgical teaching has not focused on these areas, particularly because most of us are not equipped to teach these skills. The focus must now shift to the effective teaching of these skills, and providing today’s teachers with the means to achieve this. This requires both individual and workplace recognition of the value in teaching these skills, and ensuring that there is provision in the workplace for training educators. In addition, trainers and trainees alike need to be educated how to provide effective and constructive feedback, and the difference between feedback on poor performance and bullying.

Bullying and harassment are patient safety issues. Doctors who are subjected to bullying and harassment in the workplace are not performing well and patients are therefore placed at risk. Bullying may result in dysfunctional clinical teams that fail to communicate effectively. Trainees may be afraid to speak up when they have concerns over patient safety because of the bullying culture within their unit.<sup>8,9</sup>

Many publications have discussed the culture of bullying that exists in the health sector, and the difficulties seen in trying to change that culture. What is plain is that

change cannot occur in a vacuum. There are a multitude of policies and manuals gathering dust on the shelves of every organisation and institution, but policies alone—without effective mechanisms to monitor and manage performance issues—cannot effect change. Failure to modify bullying behavior should be the subject of disciplinary action without fear of reprimand, and both professional bodies and employers should be prepared to take appropriate steps towards all health professionals when this occurs.

The EAG has challenged RACS to take a stand against bullying and harassment, by fostering cultural change and leadership, and improving education, as well as improving our complaints mechanisms. RACS is committed to answering this call, but as a profession we must all take up this challenge and work together with our colleagues across the whole of the health sector—from Medical School to Colleges, to DHBs, jurisdictions and beyond—so that the work that has begun will bring about the cultural change that is so urgently required.

Lieutenant General David Morrison led a review of bullying and harassment in the Australian Army. He is famous for the powerful statement, “The standard you walk past is the standard you accept”. It is time for us all to heed that message and act upon it.

*“Every patient has a right to expect that their healthcare is uncompromised by discrimination, bullying and sexual harassment in the practice of surgery. Every surgical trainee has a right to an education free of discrimination, bullying and sexual harassment.*

*And every healthcare worker—including every surgeon—has a right to a workplace free of discrimination, bullying and sexual harassment.”<sup>10</sup>*

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**Competing interests:**

Dr. Ferguson reports she is a surgeon and was a member of the RACS Expert Advisory Group looking at discrimination, bullying and sexual harassment. She is the chair of the Professional Standards Committee of RACS and a College Councillor.

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**REFERENCES:**

1. Royal Australasian College of Surgeons: Guidelines to Bullying and Harassment (2014)
2. Kelly S. (2004) Workplace Bullying. NZMJ: 117
3. Scott J, Blanshard C, Child S. (2008) Workplace bullying of junior doctors: a cross sectional questionnaire survey. NZMJ Digest vol 121 no 1282 pp 13-15
4. Myers M. (1996) abuse of residents; it's time to take action. CMAJ 154 pp 1705-1708
5. Quine L. (2002) Workplace bullying in junior doctors: questionnaire survey. BMJ 324: pp 878-879
6. Fnais N, et al. (2014) Harassment and discrimination in medical training: a systematic review and meta analysis. Academic Medicine 89(5) pp 817- 827
7. Pfifferling JH. (1999) The disruptive physician: A quality of professional life factor, Physician Executive 25 (2) pp56-61
8. Paice E, Smith D. (2009) Bullying of trainee doctors is a patient safety issue. Clin Teach 6: pp13-17
9. Wild J, Joshi H, Robson A, Hornby S, Fitzgerald E. (2015) Blowing the whistle: surgical trainees' experience and attitudes towards raising concerns over patient safety. BJS 102: pp 40
10. Expert Advisory Group on discrimination, bullying and sexual harassment advising the Royal Australasian College of Surgeons (2015) Report to RACS