Bullying in the orthopaedic workplace: How did we get here and where are we going?

The British Orthopaedic Trainees' Association (BOTA) recently commissioned a members' survey to identify and quantify the presence and extent of bullying in the contemporary workplace. This highlighted a number of complex issues that are relevant to trauma and orthopaedic surgeons in particular but may also have implications for the medical profession in general.

The survey was simple, asked binary questions and identified that 73% of respondents had witnessed bullying, harassment or undermining at some point. Harassment had been witnessed by 37%; sexist, racist or homophobic language had been witnessed by 23%; and 17.4% had witnessed a colleague being undermined.

This paints a bleak picture of the professional health of trauma and orthopaedic surgery in this country, and many professional bodies have rapidly aligned to demand change. A statement from the Joint Surgical Colleges and Joint Committee on Surgical Training "welcomed" this survey and this has led to a greater focus on eliminating this behaviour from clinical practice.

The British Orthopaedic Trainees' Association have responded with the "Hammer It Out" initiative and a mission statement that aspires to create a positive workplace culture and a balanced and representative workforce, in which individuals are empowered to speak up when unacceptable behaviour is witnessed.

It is perhaps more straightforward to deal with overt nastiness, including acts of public humiliation and discrimination based on gender, ethnicity or sexual orientation. This is something that tends to be visible and is simply not tolerated in contemporary society.

We are, however, a complex group of individuals and there will be a proportion in whom bigotry is an unmodifiable character trait. This initiative will not make these people good but, in order to succeed, it just needs to stop them being bad in public.

Even the most naïve among us, irrespective of their actual opinion and structure of values, should recognise that continuing with this behaviour is foolhardy. There are very clear operational guidelines within the National Health Service, and sanctions are in place that should discourage conduct of this type, even in those who remain emotionally stranded in the 1970s.

It is the subtler areas, illuminated by this survey, which, in my view, may be more difficult to manage. Some of this is due to lack of appreciation of what constitutes poor behaviour, a changing dynamic between trainee and trainer, and an environment that is under continuous change and not always in a positive direction.

F. Monsell MSc, PhD, FRCS (Orth)
F. Monsell, MSc, PhD, FRCS (Orth), Orthopaedic Surgeon, Bristol Children's Hospital
Email: fergal.monsell@btinternet.com

Until the reasons for this behaviour are investigated and properly understood, there will be little merit in attempting to modify the outward actions. The unsophisticated response of the trainer will be to explain away criticism of this type as a sample error or as the predictable result of asking the wrong questions of the wrong people. This would be a fundamental error of judgement and one which we would regret, not only because it would allow a very real opportunity to be missed but also because it would help to confirm an unfortunate stereotype.

The reason that we become formal or informal trainers is because we recognise a professional and ethical responsibility to support those who follow us and provide them with the tools that are required to negotiate independent practice. At its most basic, this should provide the trainee with the minimum skill set and knowledge base. The complexity of medical and surgical practice is unmodified by the zeitgeist, the health of the profession or changing societal imperatives, and it creates the trainer-trainee dynamic in which a culture of bullying exists or is perceived to exist.

I see the Consultant trainer as a disenfranchised member of the healthcare community, responsible for the teaching and training of individuals with whom they no longer identify. They are typically a member of "Generation X", born from the early 1960s to the early 1980s, and were trained by "Baby Boomers", born within 20 years of the end of World War II. They are responsible for the professional education, training and mentorship of "Millennials', typically born from the early 1980s to the early 2000s, who are either in current surgical training, medical school, or secondary education with an aspiration to read medicine at university.

From a cultural perspective, these groups have clearly defined social characteristics. In terms of education, the trainers of the current era shared broad similarities with their predecessors. Those of reasonable intelligence who were gifted with a good memory for facts could negotiate the system as undergraduates and during surgical training. This was an apprenticeship with clear short- and long-term rewards that existed in a stable professional environment and, although more protracted, had a predictable outcome in most cases.

It was not perfect, but the structure was constant and formed around the "Firm", with a clear chain of command from Consultant through Senior Registrar, Registrar, Senior House Officer, House Officer and Medical Student. The structure was based on a tacit system of rewards and punishments as it was essentially patronage-based. Aggressive behaviour, casual racism and sexism were tolerated as part of the cultural norm, and bullying was tolerated as part of the overall experience.

However, although the training process was frustrating at times, and was filled with components of no educational benefit, this was ameliorated by a reasonably certain future with compelling drivers including status, power and wealth. This arrangement was tenable when these drivers prevailed but there has been a fundamental change in the definition of the Consultant and a widely held perception that this utopian existence has turned to dust.

The current generation of Consultant trainers live with dissatisfaction that is influenced by the loss of perceived authority. This has been caused by a number of factors, the most tangible being the vagaries of the current and future Consultant contracts. This has also occurred in an environment in which the dynamics between those who treat and those who manage have become disconnected, in addition to the real effect of institutional financial strictures. There has also been a gradual and continuing increase in societal demands, and an increasing fear of error, which is driven internally but also by the media and judiciary.

This has created a cabal of Consultant trainers who are dissatisfied with current and future professional opportunities, who have a fundamentally different concept of what it is to learn and therefore to teach, and who are existing in a professional environment that is in constant revolution.

This group is responsible for the education, training and mentorship of the trainee, who is a product of a secondary educational system, which is structured, regulated from early teenage years and relies on frequent assessment rather than annual examination.

The undergraduate medical experience, which is no longer provided *gratis*, is largely unrecognisable to previous generations and is continually changing. Post-graduate training has uncertain short- and long-term rewards, and while the timeframe has been truncated, the educational opportunities have not been improved to accommodate this.

There is no formal structure and therefore no obvious chain of command. The system has few rewards, patronage is actively discouraged, and although the time available is substantially less, large components that have no educational or training benefit remain in place.

In the space of one generation, there has also been a fundamental change in the availability, acquisition and processing of information on a scale not seen since the advent of the printing press. There is also a reliance on alternative methods of communication, including social media, which are second nature to the trainee and poorly understood by the trainer.

There have been societal changes too, which are largely positive and include the demise of the surgeon messiah, changes in expectations of the work-life balance and a gradual change in student demographics, with gender parity in medical school. Overt bullying, casual racism, sexism and homophobic behaviour and language are not tolerated as part of the overall experience and it is a credit to the current generation of trainees that they have the wisdom to confront it.

Our trainees also live with dissatisfaction that is influenced by constant changes in working practice, driven by contract negotiations and changes in management. They are subject to the rising societal demands on the profession and are fearful of mistakes, driven by reflection that is an integral part of good medical practice, but also influenced by public expectation.

Trainees are forced to live in the moment, focusing on the next hurdle or major event including professional examination or

consultant appointment. This tends to obscure the importance of the longer game and the core skills that are required to navigate it. This has created a generation of trainees who are dissatisfied with current and future professional opportunities, with a fundamentally different concept of what it is to learn, in a professional environment that is also constantly changing.

The result is two distinct, unhappy tribes who are forced to interact on a daily basis, and the existence of *de facto* bad behaviour and behaviour that is perceived to be intimidating is not particularly surprising.

This will not be reconciled rapidly, nor as a result of a survey or a set of recommendations or directives from either the professional or legislative organisations. Until the drivers are recognised by each party, my view is that this dynamic will continue.

It may, however, be influenced by subtle changes in behaviour over a long period of time and the place to start is for each member of the trainer generation to evaluate their immediate sphere of influence, recognise what is suboptimal and make adjustments on a daily basis. "Hammer It Out" is perhaps the wrong title, and this particular crisis may require uncharacteristically soft hands as an alternative.

This requires the trainers to understand the differences in the people for whom they are responsible. It requires an appreciation that the world into which trainees were born and the society of which they are now part are different in many ways to the ones that framed their own experience. This requires empathy, which should not be anathema to individuals who have devoted the majority of their adult life to the practice of medicine.

What trainers must not forget is that the generation that follows them is as hardworking, committed, imaginative, brave and resourceful as they once were. They should appreciate that the equipment with which they have been provided in order to face the challenges of contemporary training has fundamentally changed and that these changes are simply different, not worse. They must understand that the training opportunities will not have the same structure as those experienced in their time and they must therefore be flexible in the delivery of training and ruthless in defence of their role as trainers.

They must develop communication skills that allow them to achieve this without being perceived as being authoritarian, aggressive or intimidating. The rules of the game have changed and they must recognise this for what it is.

Training continues throughout the professional lifetime, most of which is spent in independent practice. There is no simple method of acquiring the required skills, but it is axiomatic that a larger clinical database and a longer period spent practising the core skills required to conduct surgery is an advantage rather than an impediment.

The trainee should therefore not be a sleeping partner in this time of change. They have made a commitment to a lifelong involvement in the care of the orthopaedic patient and this requires investment and, perhaps, a shift in perception of what is required to succeed.

The only constant in this ever-changing professional universe is the complexity of medical practice. The trainee should recognise the intrinsic merit of ensuring that they are properly prepared at each stage of their career, irrespective of the non-clinical pressures in the working environment. It is not sufficient to expect to be trained without assuming a level of personal responsibility and ensuring that all opportunities are identified and utilised. This may at times be inconvenient but there is a requirement for self-directed learning, which will continue throughout their career.

A legitimate concern expressed by some members of "Generation X" is that orthopaedic surgeons of the future may be encouraged or forced to enter independent practice without sufficient experience, knowledge or technical skills because they cannot be acquired with current training arrangements. This puts the next generation at considerable risk of clinical error, with the attendant professional, personnel and societal penalties. It is therefore the absolute responsibility of the trainer to protect the trainee in these uncertain times and ensure that this does not occur.

 DOI: 10.1302/2048-0105.65.360555