

Workplace Bullying of Urology Residents: Implications for the Patient and Provider



Mashrin L. Chowdhury, Maha M. Husainat, and Kristina D. Suson

OBJECTIVE	To elucidate whether urology residents in the United States feel bullied by nurses, how respected they feel at work, and whether this impacts personal and patient care.
METHODS	We distributed an Institutional Review Board-approved online, validated, revised Negative Acts Questionnaire to US urology residents in their first year or above. We evaluated bullying through scoring work (total range 5-25), person (total range 9-45), and physical intimidation (total range 3-15) related bullying domains. We also solicited how respected residents feel by different staff on a Likert scale and the perceived personal and professional impact of bullying. Bullying domains were assessed with descriptive statistics and mean total bullying scores (MTBS) and demographics compared.
RESULTS	We received 102 responses (82% MD, 18% DO). One resident reported never experiencing bullying. Overall average MTBS was 28.9 ± 0.9 (17-68). 98.0%, 82.4%, and 77.5% of residents reported at least 1 incident of work, person, and physical intimidation-related bullying, respectively. DO residents reported higher MTBS than MD residents (33.7 ± 2.2 vs 27.8 ± 1.0 , $P = .015$). Higher MTBS scores were seen in residents who feared retaliation and considered transferring programs, while lower scores were seen where the resident-nurse relationship was nurtured.
CONCLUSION	Ninety percent of residents perceived some degree of bullying and report a negative impact on personal performance and patient outcomes. UROLOGY 127: 30–35, 2019. © 2019 Elsevier Inc.

Bullying in the workplace has been observed across many occupations. In the healthcare field, Meissner brought attention to bullying of novice nurses with her controversial 1986 essay, questioning whether “nurses eat their young” and providing examples of workplace hostility that drags down new nurses.¹ Since then, numerous studies have been performed both to assess the frequency and severity of nurse bullying, but also ways to prevent it.²⁻⁴

There has also been increasing academic interest in the prevalence and impact of bullying on other members of the health care team, including residents. The majority of publications report bullying by attending physicians or senior residents.^{5,6} An Australian study of general surgery residents found that 64% of residents reported some bullying, with 14% experiencing it weekly or daily.⁶ There are few reports on resident bullying by nursing or ancillary staff.^{6,7}

Urology residency is somewhat unique in comparison to other residency programs. Typically, urology residents are not in-house during call. Further, one of the most common reasons for which residents are called in for consultation is urethral catheter placement, usually a nurse task. There are no studies specifically evaluating the degree to which urology residents feel bullied in the workplace. From anecdotal conversations and experiences, we hypothesize that the United States urology residents do perceive bullying and evaluate if they perceive an impact on patient care and personal well-being.

METHODS

After receiving Institutional Review Board approval, we created an online survey via Google Forms using the validated, revised Negative Acts Questionnaire (NAQ-R). This instrument has been validated to identify bullying in the workplace over a wide range of severity and frequency, across a large, heterogeneous sample population.⁸ The 22-item questionnaire has been previously applied to general surgery residents to assess their perception of bullying by nursing staff.⁹ Our survey, including the questionnaire and additional items described below, was distributed to urology residents in their first year or above in the United States ACGME and AOA urology programs through program coordinators and directors. The survey was anonymous and voluntary.

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From the Detroit Medical Center, Detroit, MI; and the Children's Hospital of Michigan, Detroit, MI

Address correspondence to: Kristina D. Suson, M.D., Children's Hospital of Michigan, Pediatric Urology, 3901 Beaubien, Detroit, MI 48230. E-mail: kdsuson@gmail.com

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The questionnaire elicited responses from a series of questions from 3 aspects of bullying by nurses: work-, person-, and physical intimidation-related bullying. Each question was scored 1-5 with 1 being events never occurring and 5 as events occurring daily. Results were analyzed as individual answers. A new metric was created, tallying the total scores for each domain and as a whole, and means/ranges were calculated.

Residents were also asked how respected they feel by various members of the medical team, including floor nurses, OR nurses, surgical technologists, senior GU residents, GU attendings, consulting physicians, and physicians requesting a consult. Each question was scored on a Likert scale with 1 being least respected and 5 being most respected. Finally, residents were queried about perceived workplace outcomes and modifiers of bullying: fear of retaliation for reporting bullying, impact on resident performance, impact on patient outcomes, satisfaction with career choice, whether hospital culture nurtures resident/nurse relationship, and if the respondent has bullied. The survey gathered basic demographic information about the respondent: age, race, year of training, and allopathic vs osteopathic degree. Demographics were also obtained about likely bullies: same or opposite gender, and race, and level of nursing experience.

Descriptive statistics, including means with standard error and quartiles, were used to quantify the respondents. Mean total bullying scores (MTBS) were calculated for each domain and as a total, were compared between different demographic groups. We also analyzed for differences in MTBSs for the 2 binary options in the perceived personal and patient outcomes. Finally, we investigated whether as a group, residents felt more respected by certain members of the health care team and differences in MTBSs between those who felt the most or least respected. Student's *t* test, ANOVA, and chi-squared analyses were applied to detect differences, where *P* < .05 was considered statistically significant.

RESULTS

We received 102 responses, 82% (*n* = 84) MD, and 18% (*n* = 18) DO, with a mean respondent age of 30.8 ± 0.3 years old. Two residents did not complete the full survey, leaving the personal effects/outcomes portion of the survey blank. The NAQ-R results are presented in Table 1 expressed as percentages. The domain totals per resident are presented in Figure 1. The mean MTBS was 28.9 ± 0.9 (range 17-68), with mean work-related bullying 11.3 ± 0.4 (range 5-22), mean person-related bullying 13.9 ± 0.5 (range 9-38), and physical intimidation-related bullying as 3.8 ± 0.1 (range 3-10). DO residents reported significantly higher MTBSs than MD residents (33.7 ± 2.2 vs 27.8 ± 1.0, *P* < .015). Year of training did not impact perception of bullying, when comparing Uro 1 residents to Uro 5 residents (MTBS 31.5 ± 2.5 vs 30.1 ± 2.9, *P* = .708), or when comparing the scores across all 5 years of residency (Fig. 2). There was also no difference in MTBS by age of the resident (*P* = .996). Finally, no significant differences were identified in bullying rates, whether the nurse was the same or opposite gender (30.3 ± 1.6 vs 29.6 ± 1.3, *P* = .753), or same or different race (30.1 ± 1.4 vs 29.7 ± 1.4, *P* = .833).

Residents perceived different degrees of respect from various members of the health care team, as assessed using a Likert scale (*P* < .001). The mean scores for each member of the team are presented from most respect to least, with the standard errors: senior resident (4.2 ± 0.1), urology attending (3.8 ± 0.1), physician requesting consult (3.8 ± 0.1), surgical technician (3.7 ± 0.1), physician consulted by resident (3.7 ± 0.1), operating room nurse (3.5 ± 0.1), and floor nurse (3.4 ± 0.1). The residents in the top total respect quartile, or those who felt more respected, had lower total bullying scores than those at the bottom quartile 24.7 ± 1.0 vs 34.9 ± 2.2 (*P* < .001).

The personal and patient outcome impact results are presented in Table 2. Residents who feared retaliation for reporting

Table 1. Negative Acts Questionnaire—revised responses

Has a Nurse Ever . . .	Now and				
	Never (%)	Then (%)	Monthly (%)	Weekly (%)	Daily (%)
<i>Work-related bullying questions</i>					
Withheld information which affected your work performance?	40	45	7	7	1
Ordered you to do work below/above your level of competence?	27	29	14	21	9
ignored your orders?	12	47	14	20	7
Pressured you not to report an incident, noncompliance, or/and short-comings of nurses?	77	19	2	1	1
Asked you to perform their task?	10	32	20	26	12
<i>Person-related bullying questions</i>					
Humiliated or ridiculed you in connection with your work?	52	37	5	5	1
Spread gossip or rumors about you?	62	30	5	3	0
Ignored or excluded you?	51	33	8	5	3
Made insulting or offensive remarks about you, your attitude or private life?	62	31	4	4	0
Hinted or signaled that you should quit?	94	4	1	1	0
Repeated reminders or criticized you of your errors or mistakes?	68	25	3	2	2
Ignored you or had a hostile reaction when approached?	29	35	21	9	6
Made false allegations against you?	65	30	2	2	1
Made you the subject of excessive teasing and sarcasm?	85	10	2	2	1
<i>Physical intimidation-related bullying questions</i>					
Shouted at you or made you the target of anger?	59	33	6	2	0
Showed any intimidating behavior toward you?	83	12	3	1	1
Made physical threats against you, or physically abused you?	100	0	0	0	0

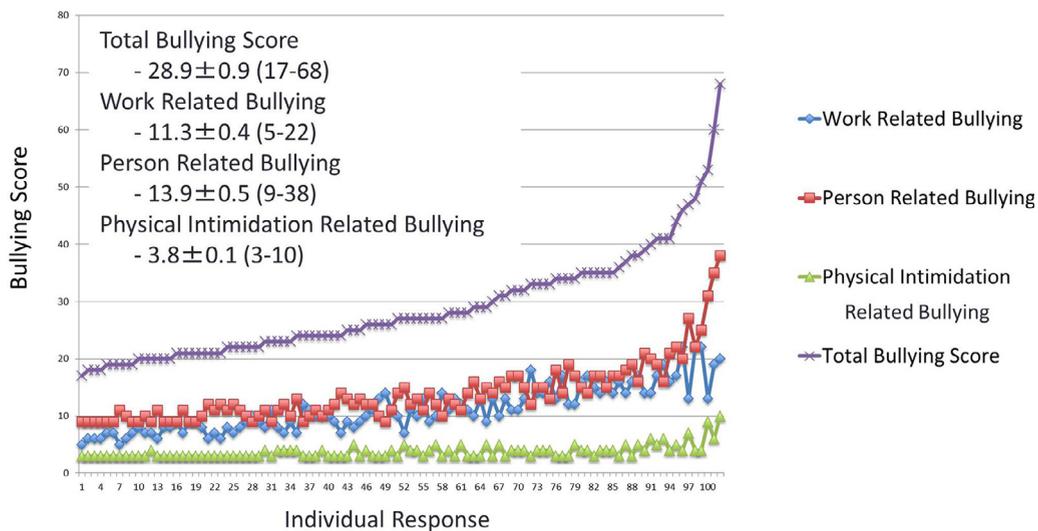


Figure 1. Individual responses to work, person, and physical intimidation bullying, and their total, presented from least to most perceived bullying. (Color version available online.)

bullying, and those who felt bullying either negatively affected his or her performance or patient outcomes reported higher MTBSs. Likewise, the 5% of residents considered transferring programs or specialties due to bullying had higher MTBSs, while the 40% who felt that their hospital cultures fostered the resident-nurse relationship had lower MTBSs. Personal recollection of bullying behaviors did not influence MTBS.

DISCUSSION

As hypothesized, urology residents do perceive bullying behaviors from nursing staff. While the urology subspecialty does not have a reputation of hostility, we found that 98% of residents perceived some degree of bullying at work. The residents in our survey report potential for negative impact on personal performance and patient outcomes. Not only do we know that bullying behaviors lead to patient care errors, there are increasing rates of physician burnout and even suicide.⁵ These very serious matters may be prevented by awareness and promoting a better work environment.^{5,10} While 98% does seem high, it is all in the definition of bullying. Bullying has been

described in various ways that include behavior that is intimidating, hostile, or destructive, and that which can cause fear or anxiety, physically or emotionally, among those who are affected.^{9,11,12}

Since Baldwin and Daugherty stated in one of the first reports of resident bullying that 98.6% of PGY 1 residents experienced at least 1 instance of mistreatment,¹³ increasing numbers of studies have focused on resident bullying. A national Canadian survey of medical residents and interns reports the incidence of bullying as high as 72%. Abuse was reported to be by attending/staff physicians, nurses, and other residents in this review. Encouragingly, over 50% of the residents also reported an effective resource for addressing bullying behaviors.⁷ Chadaga et al published a recent survey of ACGME residents from 2015 reporting a 48% incidence of bullying occurring in residency. The study reports that most instances of bullying occurred from attendings and nurses at a rate of 29% and 27%, respectively.¹⁴

Within the field of surgery, there is a growing body of bullying literature. A study of general surgeons, both residents and attendings, found most commonly that attending surgeons were the bully (39%), followed by administration (20%), and nurses (11%). In this study, 38% experienced some item on the NAQ-R daily or weekly. This population most commonly cited that the instances of bullying were recommendations being ignored and an excessive workload.⁶ In a study that focused on bullying of general surgery residents by nurses using the NAQ-R, the most commonly encountered behavior they reported was work-related, where orders are ignored. They also found that ignoring the resident or greeting him or her with hostility had been encountered by over 70% of residents. Most concerning, over a third had been shouted at or the target of anger by nurses, and more than 20% had been subjected to intimidating behaviors.⁹ In our study, we found that work-related

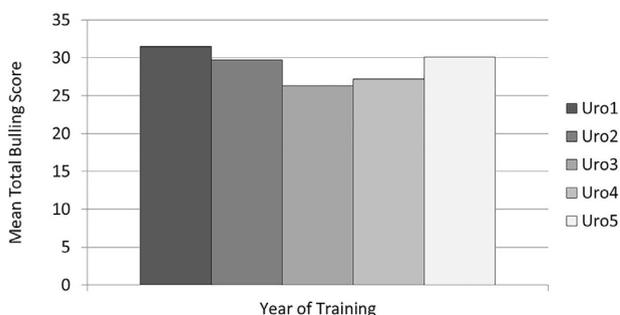


Figure 2. Bullying rates did not vary significantly across level of training ($P = .309$) or specifically between Uro 1 or Uro 5 residents: 31.5 ± 2.5 vs 30.1 ± 2.9 ($P = .708$).

Table 2. Personal effects/outcomes of workplace bullying

Effect	Yes		No		P Value
	N (%)	MTBS ± SE	N (%)	MTBS ± SE	
Do you fear retaliation if you report bullying?	30 (30.0)	34.4 ± 1.8	70 (70.0)	26.8 ± 1.0	<.001
Has bullying affected your performance in residency?	15 (15.0)	39.5 ± 2.6	85 (85.0)	27.2 ± 0.9	<.001
Has an act of bullying negatively affected patient outcome?	36 (36.0)	35.7 ± 1.7	64 (64.0)	35.3 ± 0.8	<.001
Have you considered transferring residency programs or specialties due to bullying?	5 (5.0)	30.8 ± 5.9	95 (95.0)	28.4 ± 0.9	.003
Is the culture of your hospital one, which nurtures the resident-nurse relationship?	40 (40.0)	24.9 ± 0.9	60 (60.0)	31.8 ± 1.3	<.001
Have you behaved in a way which others might consider bullying?	24 (24.0)	31.9 ± 2.2	76 (76.0)	28.2 ± 1.0	.087

bullying was more common, where 12% of residents reported nurses asking them to perform their task daily and overall 90% reported it to happen at least once. We had no residents report any physical threats or abuse; however, we did find that 71% reported being ignored or had a hostile reaction when approached.

Resident bullying can impact performance and patient care. In our study, 15% felt that it impacted their performance, while 36% felt that it impacted patient care. A survey of internal medicine program directors found that over 30% of them believed there to be bullying within their programs. Of those who reported bullying, 63% felt it harmed the learning environment, while even 21% of those who did not report it found it harmful to resident education. While they did not comment on potential patient outcomes, 23% reported a decline in resident performance, which certainly could impact patient care, while 14% found “depressive behavior” in the victim and 9% considered leaving the program.¹⁵ In 2008, the Joint Commission set out a Sentinel Statement report with the first line stating “intimidating and disruptive behaviors can foster medical errors” and further stating that bullying behaviors should not be allowed in the hospital. Furthermore, they made several recommendations in addressing the problem including a “zero tolerance” policy or pathways for reporting these types of behaviors.¹¹ We found that residents who reported their programs nurtured positive nurse-resident relationships and those in which residents felt respected were associated with less bullying. Creating a culture of mutual respect may help decrease workplace hostility.

Bullying and burnout also seem to be related. Burnout is already a hot topic in medicine in general and to urologists in particular. The 2016 American Urological Association Annual Census reported more than 36% of urologists experienced burnout, with the highest rates among those younger than age 65. Working less than 40 hours per week and seeing fewer than 40 patients per week was protective,¹⁶ and unlikely to happen during residency. For residents who do experience burnout, it is potentially devastating. In a survey of general surgery residents and attendings, 75% of residents reported burnout symptoms, and nearly 40% met criteria for depression. Most sobering, 12% of general surgery residents reported

suicidal ideation in the previous 2 weeks. While residents recognized symptoms of burnout in each other, only 23% of attendings realized how pervasive a problem it was. Similarly, only 25% of attendings were aware of the prevalence of depression in their programs. While residents and staff reported tight schedules, avoidance/denial, and negative stigma to hinder treatment,¹⁷ a lack of awareness about the problem also limits system-based solutions. Physician burnout has also been linked to post-traumatic stress disorder in residents. A study of surgical residents across the United States reported that 22% met the screening criteria for post-traumatic stress disorder, while additional 35% were deemed “at risk.” One of the big stressors linked to post-traumatic stress disorder was found to be bullying.¹⁸

To protect our residents and patients, bullying must be prevented. Two potential avenues include education and institutional interventions. One reason nurses in particular may treat residents in a way they deem bullying, be it intentional or accidental, is a lack of information about what residency really means. In a study of nurse knowledge about general surgery residents, 40% did not even know that interns were physicians; this could explain reluctance to follow orders. Many believed that the primary role of residency was to study, not care for patients, with 32% believing that residents paid to work and were not paid employees. There was also limited knowledge about resident work limits, such as the 80-hour work week.¹⁹ Within the field of nursing, hospital- and unit-based protocols to prevent bullying have been effective. In a study that assessed both the degree of bullying with the NAQ-R and bullying prevention measures with their own survey, they found that nurses whose employers work to prevent bullying in fact did experience less bullying.² If bullying cannot be completely eliminated, one strategy to mitigate its impact may be increasing a sense of personal control. A study of mental health care employees and nurses found that workers in more control over their lives, either professionally or personally, had less burnout, suggesting they coped more effectively with bullying. They recommend maximizing autonomy at work, where possible.⁴

Little research has been performed in a prospective fashion to delineate how to best eliminate resident

maltreatment. Leisy's review of resident bullying concluded with the following recommendations: education about what constitutes bullying and its ramifications, instruction on institutional reporting of bullying/harassment, instituting anonymous reporting, soliciting resident feedback, encouraging a zero-tolerance bullying culture, promoting resident wellness, and increasing "flexibility in training and exit strategies."⁵ A protective factor against burnout in urologists was "working in a positive work environment,"¹⁰ so factors that improve physician burnout are likely to decrease bullying as well. They also cite steps at the individual and institutional level to battle burnout. Again, some seem to overlap with ways to either a decrease bullying or its effects. The individual should work on building resilience, and as mentioned above, find ways to feel in control. The institution should focus on a culture that values teamwork and communication.¹⁰

Our study should be viewed with its limitations in mind. As per our Institutional Review Board's request, the survey was distributed to program directors and coordinators, to then be distributed as they felt appropriate. There may have been bias in its distribution or in who elected to complete it, and we are unable to determine a response rate. Further, due to the subjective nature, what one considers bullying will not be viewed the same by another. However, the definition of bullying is the experience of the individual. There also may have been recall bias, as we asked participants to reflect upon their past experience. Finally, the impact of bullying is also completely subjective.

With confirmation that the surveyed residents do perceive bullying, with a concomitant impact on patient care, further research may investigate factors that lead to bullying and if individual and patient outcomes are affected in an objective fashion. With 98% of the residents reporting bullying, additional study into its prevention is warranted. While this would imply a near universal experience of bullying, investigation into differences by gender, sexual orientation, or other resident characteristics may help identify groups at particular risk. As residents in programs which nurture the nurse/resident relationship report lower MTBSs, promoting a positive work environment would seem a logical first step. Variation may exist between hospital setting (clinic, operating room, and floor), geographic region, type of hospital (community vs academic center), or away rotations at outside institutions. Further study into the type of work environment where the bullying occurs can direct interventions for greater impact.

CONCLUSION

The vast majority of residents report having experienced bullying behaviors, and over a third of residents believed that bullying adversely impacts patient outcomes. Awareness that bullying exists in the workplace and the different ways it may manifest is the first step in mending the issue. Resources, like anonymous reporting or program director/

coordinator awareness, may help promote solutions. Prospective research into the prevention of bullying within the hospital is warranted to improve the delivery of patient care and resident well-being.

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EDITORIAL COMMENT

The authors of this study should be commended for providing meaningful data on the phenomenon of bullying in residency



training. This issue is not unique to urology or to the residency training environment, but it does deserve formal and proactive attention within our specialty. They correctly point out the pervasive impact of hostile and disrespectful behavior on the quality of job satisfaction, work burnout, and patient care and outcomes. In this study, 98% of residents perceived bullying, 36% felt that bullying affected patient care, and 63% felt that it harmed the learning environment.

While the study focuses on the relationship between residents and nurses, bullying may be observed at all interactional levels within the health care team, as evidenced in the published literature on surgery residency training and from other specialties. A heightened awareness of the many potential facets of inappropriate and unsupportive behavior in the training setting, and the manner in which such interactions affect the quality of patient care and of the learning environment, is essential to our efforts to remedy the situation.

There is sufficient evidence that the prevalence of bullying in our training environment is pervasive to prompt our national urologic educational leadership to spearhead a comprehensive effort to measure the impact of the problem, identify individuals at particular risk, and create a broad-based educational and remedial initiative to mitigate the adverse impact on training and patient care.

Michael Coburn, Baylor College of Medicine, Scott Department of Urology, Houston, TX

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AUTHOR REPLY



The authors agree that all interactions within the healthcare system have the potential for negative impact not only on the resident, but also on patient care. Further, we agree that it is imperative that we gain a better understanding of at-risk individuals and especially problematic intersections. Further, the specialty of urology has a chance to be an early leader, as the concept of physician well-being gains national momentum.

The Accreditation Council for Graduate Medical Education (ACGME) started a physician well-being initiative, with numerous strategies to foster physician well-being, from offering their journal as a venue for publishing research in this area, to collaborations with other national organizations.¹ One of the Common Program Requirements for accreditation is dedicated to well-being, mandating that programs educate their faculty and residents about the signs and symptoms of burn-out and depression,² both of which are associated with bullying. In 2017, they increased the breadth and specificity of the program requirements in resident well-being.² Additionally, the ACGME hosts conferences to promote physician welfare. Their first Symposium on Physician Well-Being focused on resident, fellow, and faculty mental health, including the impact of medical culture.³ The ACGME web site is a valuable resource for residents

and faculty, offering a compendium of information concerning physician well-being, mental health, and improving the work environment.

As mentioned in our manuscript, the American Urological Association (AUA) investigated burnout as part of their 2016 annual census, finding more than 36% of urologists reported burnout.⁴ The AUA also recognizes that this is a problem for young urologists. The 2018 Residents Forum at the annual meeting included a panel, “Wellness, Burnout, and Sustaining Your Career,”⁵ and the AUA recently sponsored an essay contest for residents and fellows about resilience. As a cornerstone of the AUA mission is education, they are ideally situated to disseminate curricula to residents and attending urologists about physician well-being and its impact of patient care.

One of the limitations of our study was its narrow scope. Despite the relatively low number of respondents, the prevalence of perceived bullying was so great, we agree that a larger study from an organization with greater reach is warranted. Initial study into individual risk factors and impact on resident health is a start, along with evaluating other potential contentious relationships in the healthcare team. As our survey responses suggest potential compromise of patient care, patient outcomes are another avenue of study. Finally, prospective research into interventions may address if education and attempts to influence hospital culture ameliorate the degree and impact of bullying on residents. As the ACGME and AUA have dedicated resources to physician welfare and burnout, both organizations are positioned to recognize bullying amongst various members of the healthcare team as a potential detriment to resident well-being and support a broader study.

Mashrin L. Chowdhury, Maha M. Husainat, Kristina D. Suson, Detroit Medical Center, Detroit, MI; Children's Hospital of Michigan, Detroit, MI

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