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Workplace Bullying in Healthcare: Ethical Implications & Impact

Healthcare professionals are trained to save lives and provide patient support while maintaining strict ethical standards for patient care. However, this commitment to patient care underlies a crisis of workplace bullying, a major contributor to mental health struggles. Workplace bullying spans across a spectrum from explicit acts such as verbal and nonverbal abuse, intimidation, threats, or sabotage to more subtle forms like exclusion from conversations, dismissed inputs, and unrealistic expectations. These behaviors have become normalized in healthcare, which often starts during training years and persists throughout careers. Additionally, hierarchical structures ingrained in healthcare settings cause power imbalances that create hostile environments that make it difficult to challenge due to fear of retaliation, which even extends to bystanders. Healthcare professionals experience increased stress, anxiety, depression, and burnout due to these workplace dynamics, affecting marginalized groups the most. This results in workforce shortages, high turnover, increased medical errors, poor communication, and reduced compassion. Ethical principles that guide patient care also extend to relationships among healthcare professionals, making workplace bullying a serious ethical concern. For example, it violates the principles of nonmaleficence by causing emotional and mental harm, violates standards of justice through unfair treatment and power struggles, and undermines autonomy by silencing or implicating fear to limit self-advocacy. Physician assistants (PAs) who navigate back and forth between physicians, nurses, and administration can catch themselves in challenging hierarchical dynamics, making them vulnerable to workplace bullying. They can face extreme pressure from supervising physicians, resistance from nursing staff, and/or unrealistic expectations from administration. This can limit autonomy, create moral distress, and hinder the ability to provide patient-centered care, the cornerstone of PA practice.

To start, the roots of healthcare workplace bullying can often be traced back to early stages of clinical training, where mistreatment is normalized as part to become a “competent” provider. These behaviors are often framed as “rites of passage” rather than recognized harmful behaviors, as people may claim that they build resilience and the character necessary to “survive” in the healthcare field. A qualitative study that was performed with 10 medical students in Sydney, Australia, found that verbal humiliation, exclusion, and undermining behavior were normalized as part of becoming “tough enough” to survive in medicine (Colenbrander, L., et al., 2020). Students reported being routinely yelled at during rounds, dismissed by supervisors, and intentionally placed in demeaning roles, such as coffee runs for the staff. These behaviors were inflicted by senior clinicians who justified them as a part of forming a “professional identity”, which further reinforces the false idea that true resilience comes from silently enduring mistreatment (Colenbrander, L., et al., 2020). Rather than challenging these toxic dynamics, it is often passed down to replicate the tough training they endured, mistaking trauma for tradition and toughness for competence. This study reflects the widespread normalization of bullying during early medical training as an unspoken cultural norm, creating an environment that makes it difficult to challenge mistreatment. This theme is reinforced by a systematic review and meta-analysis, which evaluated bullying among medical residents across 13 studies with over 44,000 participants (Alvarez Villalobos, N. A., et al., 2023). The analysis found a pooled prevalence of 51%, with women and racial/ethnic minority residents facing significantly higher rates of mistreatment. This reveals structural inequities that normalize abuse, particularly toward marginalized groups. In addition, this practice causes mental and emotional harm and creates an environment where students/trainees feel unable to speak up due to fear of retaliation from authority figures. Even well-intentioned educators may unknowingly reinforce this culture, believing that burdensome conditions are part of building character and competence.

Bullying that begins in clinical education often persists, impacting healthcare professionals through all disciplines and career stages. This toxic culture is a widespread and detrimental issue affecting

nurses, physicians, and other healthcare professionals, with consequences for staff well-being and patient care. A cross-sectional analysis of a survey that was given to 1,354 inpatient staff nurses explored the associations between the work environment, workplace bullying, and patient outcomes (Pogue, C. A., et al., 2022). Results of the study suggested that 40% of the nurses reported experiencing workplace bullying in the past 6 months. Despite recent advancements in promoting professionalism, collaborative practice, and teamwork, the prevalence of bullying still remains high. The nurses who experienced workplace bullying were less likely to report “good/excellent nurse-reported” quality of care and a “favorable patient safety grade” compared to those who did not experience bullying (Pogue, C. A., et al., 2022). This shows how workplace bullying negatively impacts the ability to deliver high-quality care, resulting in poorer patient outcomes, and this stems from increased stress and decreased morale. Interestingly, the study found no correlation between bullying and age or years of work experience, contradicting the idea that newer nurses are most at risk and the phrase of nurses “eating their young”. This demonstrates that bullying is a widespread issue that transcends experience levels, emphasizing the need for interventions targeting workplace culture as a whole rather than specific groups or individuals. Likewise, in academic medicine, female physicians are disproportionately experiencing similar patterns of mistreatment. A survey-based study of 547 female physician graduates of an executive leadership program in 2021 found that 85.3% of the physicians reported experiencing mistreatment during their careers, and 61.9% said they had been bullied at work (Iyer, M.S., et al., 2023). This was not limited to the early years of their training, as many reported bullying while already practicing as attending physicians. One participant in the study reported that “I became afraid to speak at meetings. The bullying and my fear hurt others’ perception of my abilities,” illustrating how bullying hinders the physicians’ professional growth and creates a toxic work environment (Iyer, M.S., et al., 2023). This limits effective teamwork, communication, and ultimately, the quality of patient care. Moreover, the bullying behaviors made many participants second-guess their place in leadership and believe that “it seems to get worse the higher you go” (Iyer, M.S., et al., 2023). This illustrates that bullying not only affects the mental or emotional well-being but also reinforces gender barriers and makes it harder to move forward in their

career. From nurses who report lower patient safety grades and quality of care to female physicians who are silenced, excluded, or pushed out of leadership roles, these patterns reveal how bullying contributes to negative clinical outcomes, pushes individuals out of the field altogether, limit growth opportunities, and contributes to the ongoing culture that is driven by “toughing it out” rather than thriving through mutual trust and collaboration.

While extensive research has been done on workplace bullying across various healthcare professions, such as nurses and physicians, relatively little attention has been given to PAs. Given the rapid growth of the PA profession and its unique role of bridging physicians, nurses, and administration, PAs face a plethora of unique challenges and workplace dynamics. Working in collaborative settings and with increasing autonomy through initiatives such as Optimal Team Practice, PAs may face backlash that increases the risk of workplace bullying due to potential infringement on existing clinical hierarchies and interprofessional relationships. The PA workforce is predominantly female, which further introduces a gendered dimension to how bullying may manifest, similar to the study previously mentioned regarding female physicians. A pilot study that was done in 2017 attempted to examine the prevalence of such behaviors among PAs and physicians in 3 different ED settings (Volz, N. B., et al., 2017). Researchers found that 22.2% of respondents reported a time within the past year when bullying negatively impacted patient care. Additionally, 11% stated that they felt a sense of dread about coming to work, indicating that the effects of bullying extend beyond the workplace into the scope of emotional and mental health. Despite this, only 32.2% reported that bullying had been addressed in their hospital, and 65.6% felt safe escalating these issues, highlighting a systemic issue where a lack of institutional acknowledgment or fear of retaliation allows bullying to persist. Although only 19.8% of the respondents in this study were PAs, the data presents other interesting findings. For example, the study found that female and “mid-level” providers were disproportionately more likely to be the targets of shouting, with 77.8% of the surveyed mid-level providers identifying as women. The study also noted that female and “mid-level” providers frequently faced demeaning comments, harmful rumors, exclusion, and disrespect regarding clinical

decision-making. Regardless of whether they advocate for themselves, their concerns often go unheard or unaddressed. Encompassing all of these findings into PA practice, it is clear that workplace bullying is a significant threat to both the provider and patients. As the profession is predominantly a female workforce working in high-intensity settings like surgical subspecialties and emergency medicine, PAs face unique pressures such as ambiguous team roles, gender biases, and being perceived as “mid-level” or “assistants”, all of which increase their vulnerability to workplace bullying and undermine their professional authority.

Furthermore, healthcare workforce bullying does not only involve the bully and the victim. It is important to recognize and acknowledge that these events frequently occur in the presence of others, making bystanders a critical part of this dynamic. Recent studies have highlighted the broad impact of witnessing these events has on bystanders, revealing that even simply observing an incidence of bullying can lead to poor emotional and mental well-being and compromised clinical performance. Bystanders have a unique role in shaping the outcomes of bullying incidents. For example, some may actively intervene to stop the behavior (defender role), some may remain passive and choose not to get involved (outsider role), and some might even contribute to the bullying (assistant role). These different roles and reactions can either help reduce the harm caused by bullying or allow it to persist and worsen. A longitudinal survey included 1,144 healthcare employees, including physicians, nurses, and nursing assistants, to assess how observing bullying and different bystander roles (assistant, defender, or outsider) influenced perceived quality of care, work engagement, and turnover intentions. According to the results, both the outsider role and the assistant role were associated with decreased work engagement and perceived quality of care, as well as increased intentions to leave the job. On the other hand, the defender role led to an increased work engagement (Holm, K., Jönsson, S., & Muhonen, T., 2023). The results of this survey show that by taking on a defender role against bullying, healthcare workers can safeguard against potential harm. This highlights the ethical imperative for healthcare organizations to actively foster a workplace culture where staff feel safe, supported, and empowered to intervene when an incident

of bullying occurs. Creating a culture that encourages bystander intervention is essential for preserving team dynamics, reducing burnout, and maintaining high-quality patient care.

Therefore, to tackle the persistent issue of bullying in healthcare, a multifaceted approach involving reforms to policy, culture, and education is needed, as there is no “one size fits all.” Many healthcare institutions lack formal reporting systems specifically for workplace bullying, which leaves many incidents unaddressed. Despite policies from organizations like the American Medical Association (AMA) that have been enacted to lessen the prevalence of bullying, this issue still remains prevalent, indicating the need for further solutions. For example, zero-tolerance policies with real consequences alongside mentorship and upstander/bystander training should be implemented to dissuade the act of bullying (Iyer, M.S., et al., 2023). Bystander intervention training programs can be implemented that consist of hands-on simulations to help staff recognize, respond to, and report bullying without fear of retaliation. Encouraging staff to speak up is challenging, but essential. Implementing a confidential and anonymous reporting system can help with that initiative. To break the cycle of bullying that often stems from clinical training settings, adding accessible reporting channels that do not interfere with grading or evaluations of students can be implemented, so they can speak up without any fear of retaliation. In addition, training programs should incorporate structured education on recognizing different forms of mistreatment among the workforce, how to set professional boundaries, and fostering a culture of respect. It is also crucial to address how certain behaviors may be normalized by senior staff. This can be done through mentorship programs, leadership training, and strict accountability measures held by the institution(s). With new generational perspectives, increased awareness through social media, and advances in technology, they can offer tools to help break down silence, challenge outdated behaviors/culture, and promote transparency. Altogether, these changes help foster an environment where respect is the norm and where students and healthcare professionals feel safe to learn, grow, and advocate for themselves. This can create a positive domino effect on teamwork and lead to improved health

outcomes for patients and staff, supporting the goals of the triple aim of healthcare. By prioritizing early and consistent interventions, the healthcare culture of bullying can be knocked down.

Overall, workplace bullying is a universal threat that transcends various healthcare settings and disciplines. It jeopardizes the well-being of healthcare professionals, violates ethical principles, and ultimately compromises patient care. Rooted in hierarchical structures and normalized behaviors passed down through clinical training and practice, this issue contributes significantly to burnout, staff turnover, and poor team dynamics. Studies have shown that despite growing awareness over the years, workplace bullying remains highly prevalent, indicating flaws in the current system. Confronting this issue requires a multifaceted approach with standardized policies, accessible and anonymous reporting, mentorship, bystander empowerment, and cultural change in the workplace. As integral members of the healthcare team, PAs are both at risk for workplace bullying and positioned to help combat it. By clarifying their professional roles within the team, advocating for visibility of their scope of practice, and serving as a collaborative role, PAs can serve as bridges to foster communication and teamwork to help mitigate bullying behaviors and enhance patient care. Ultimately, creating a culture of respect, safety, and inclusion is not optional nor just ideal. It creates an environment where every member of the healthcare team can thrive, contribute, and deliver compassionate, high-quality care that patients deserve. This is imperative to sustain the healthcare workforce and quality.

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