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PROMOTING A CULTURE OF RESPECT IN CARDIOTHORACIC SURGERY: NAVIGATING CHALLENGES IN UNDERSTANDING UNETHICAL BEHAVIOUR

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Abstract. Promoting a culture of respect in cardiothoracic surgery: navigating challenges in understanding unethical behaviour. Sydorenko A.Yu., Spindler H. *Unprofessional behaviour in the workplace, such as bullying, harassment, and discrimination, remains common in the cardiothoracic surgery unit. Despite its prevalence, there is little consensus on what constitutes unprofessional behaviour in the workplace of a cardiothoracic surgeon. In this review, we aim to narrow down the definition of unprofessional behaviour among cardiothoracic surgeons, identify its prevalence and the factors contributing to it, as well as explore potential preventive and support measures. We searched the MEDLINE and Web of Science databases (2000-2022), focusing on publications within psychology, medicine, general surgery, and cardiothoracic surgery for inclusion in a focused review. The current review identified 89 papers that highlight the complexity of defining unprofessional behaviour and its prevalence in cardiothoracic surgery units. Psychosocial professional challenges, hierarchical relationships within the medical team, and a high-stress environment may prompt unprofessional behaviour, which can manifest in both overt and covert actions. Such behaviour negatively impacts medical services for patients, the psycho-emotional state of employees, and the overall functioning of the medical institution. The most effective support measures are characterized by being proactive, anticipating potential problems before they occur. Unprofessional behaviour should be considered an organizational concern, not merely an issue between individual team members. This perspective is essential for fostering a healthy work environment. The leaders of cardiothoracic surgery, given their high status and authority, play a pivotal role in this regard; their focus on inclusiveness of employees with lower status or responsibility is crucial for promoting a culture of psychosocial safety. This culture should be characterized by trust, honesty, and mutual respect, ensuring that every team member feels valued and respected. By prioritizing these values, leaders can minimize the risk of unprofessional behaviour, ultimately leading to an improvement in the quality of medical services for patients, an improvement in the psycho-emotional state of employees and the functioning of the organization as a whole.*

Реферат. Сприяння культурі поваги в кардіоторакальній хірургії: подолання викликів у розумінні неетичної поведінки. Сидоренко А.Ю., Спіндлер Г. *Непрофесійна поведінка на робочому місці, така як булінг, переслідування та дискримінація, залишається поширеною у відділенні кардіоторакальної хірургії. Незважаючи на її поширеність, немає єдиного розуміння того, що саме вважається непрофесійною поведінкою на робочому місці кардіоторакального хірурга. У цьому огляді ми ставимо за мету уточнити визначення непрофесійної поведінки серед кардіоторакальних хірургів, визначити її поширеність та фактори, що сприяють її виникненню, а також дослідити можливі заходи превенції та підтримки. Ми здійснили пошук у базах даних MEDLINE і Web of Science (2000–2022 роки), зосереджуючись на публікаціях у галузях психології, медицини, загальної хірургії та кардіоторакальної хірургії для включення в цільовий огляд. Поточний огляд виявив 89 наукових статей, які підкреслюють складність визначення непрофесійної поведінки та її поширеність у відділеннях кардіоторакальної хірургії. Психосоціальні професійні виклики, ієрархічні відносини в медичній команді та високий рівень стресу можуть спричиняти непрофесійну поведінку, яка може проявлятися як у відкритих, так і прихованих діях. Така поведінка негативно впливає на медичні послуги для пацієнтів, психоемоційний стан працівників та функціонування медичного закладу. Найбільш ефективні заходи підтримки характеризуються проактивністю,*

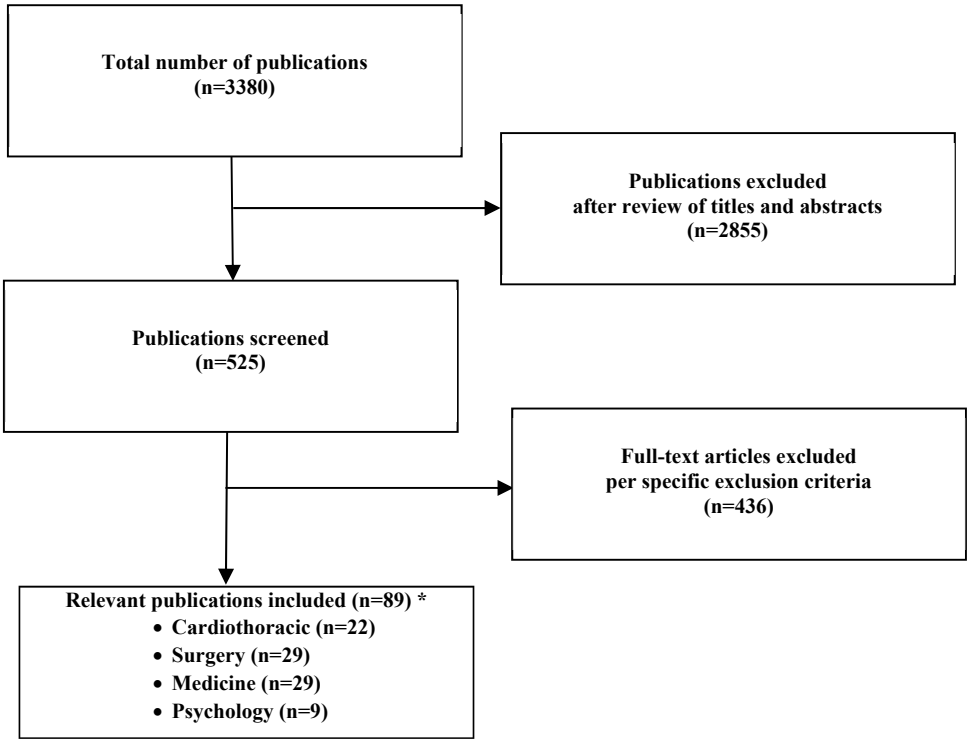
передбачаючи можливі проблеми до їх виникнення. Непрофесійну поведінку слід розглядати як організаційну проблему, а не лише як питання взаємин між окремими членами команди. Така перспектива є важливою для створення здорового робочого середовища. Лідери кардіоторакальної хірургії, зважаючи на свій високий статус і авторитет, відіграють ключову роль у цьому питанні; їхня увага до інклюзивності працівників з нижчим статусом чи відповідальністю є вирішальною в сприянні культурі психосоціальної безпеки. Така культура повинна характеризуватися довірою, чесністю та взаємоповагою, забезпечуючи, щоб кожен член команди відчував себе цінним і шанованим. Пріоритетність цих цінностей з боку лідерів дозволить знизити ризик непрофесійної поведінки, що в кінцевому підсумку приведе до покращення якості медичних послуг пацієнтіам, поліпшення психоемоційного стану медичних працівників та функціонування організації загалом.

In 1883, Theodor Billroth, one of the fathers of modern surgery, wrote: “a surgeon who operates on the heart should lose the respect of his colleagues” [1], to warn his colleagues against such endeavours, which at the time were considered high-risk and dangerous procedures. Today, we recognize that the profession of a surgeon is highly exigent and requires sufficient confidence and courage to take necessary risks when operating, which requires significant self-confidence when carrying out procedures [2]. However, this should be coupled with openness in listening to clinician-based judgement from colleagues about acceptable standards of workplace behaviour, both in terms of patient-related and intercollegiate behaviour. Excessive self-confidence and unwillingness to listen to the opinions of teammates may lead to misconduct, as in the Bristol Heart Scandal, in which surgeons refused to listen and respond to the opinions of their colleagues, which resulted in an increased death rate following cardiac surgeries over 7 years [3]. In turn, other types of unprofessional behaviour in the workplace (UBW) may be characterized as intercollegiate, such as offensive behaviour, which may involve bullying, e.g. a hostile or rude tone [4], discrimination, e.g. unreasonable non-admission to the operating room [5, 6], sexual harassment, e.g. sexist comments, being told sexually crude stories, and being exposed to offensive displays [7, 8]. The two types of UBW may be linked in the sense that when a consensus between healthcare employees with high and lower status related to patient-related UBW is not reached, this increases the risk of intercollegiate offensive behaviour directed towards the lower-status colleague. Moreover, a supervisor’s UBW may lead to trainees’ disillusionment with their area of specialisation ending in them terminating their position. As such, UBW may not only have patient-related but also organizational consequences as cardiothoracic (CT) surgery may lose potentially promising future specialists [9]. In the literature, UBW may be linked to the understanding, that to become a successful surgeon one must be able to “take the heat” as being a surgeon is a highly stressful profession and hence, UBW may be considered a way of preparing a younger colleague for the profession. Another explanation is more focused on individual factors, i.e. suggesting that the personality of the supervisor is important in determining the risk of UBW. In this paper, we aim to focus on patient-related and collegiate UBW that emerges within a team, when there is a lack of openness in discussing patient-related issues, as well as intercollegiate UBW that are not instances of conscious hazing of lower-status colleagues, but rather unconscious replication of a negative workplace culture. We have chosen this focus, as both types of UBW may be related to an unconscious inclination to continue an unhealthy workplace culture, whereas the focus on potential hazing and the impact of individual factors may be seen as special cases, that may or may not be related to these more general aspects of the working culture in cardiac surgery. From this follows, that our aim is to look at the organizational culture, rather than the role of the individual. To address UBW as an underlying cultural propensity in organizational culture, it is necessary to build a shared understanding of the causes and consequences of UBW to establish group values in the medical team regarding what patterns of behaviour would be considered unprofessional and professional, respectively. Therefore, the purposes of the current review are 4-fold: 1) to inform CT surgery team members of what may constitute UBW; 2) to increase our understanding of risk factors for UBW; 3) to assist in recognizing the consequences of UBW; and 4) to identify available interventions. In turn, we believe this knowledge may aid CT surgery leaders in creating a proactive approach to instances of UBW, which makes it an organizational, rather than an individual issue to address.

MATERIALS AND METHODS OF RESEARCH

For this review, a literature search of scientific publications in the English language was carried out to identify articles and other forms of information that were relevant to the topic of UBW in CT surgery divisions. We searched the MEDLINE and Web of Science databases (2000–2022) using the following primary search terms: “unethical behaviour,” “unprofessional behaviour,” “disruptive behaviour,” “undermining behaviour,” “bullying,” “discrimination,” “sexual harassment,” “gender biases”; secondary queries were performed by adding terms such as

"surgery," "medicine," "cardiothoracic,"; finally to address our final aim, tertiary search terms were added, which included "strategies," "interventions," "program." The titles and abstracts of these publications were then reviewed by the first author to identify those that fit the inclusion criteria for this review (see below). However, we discussed that UBW at the CT surgery was presented in a limited number of hits, so we decided to widen the search criteria by including publications with UBW studies in other surgical specialities and general medicine. All articles fulfilling one or more of the inclusion criteria related to the aims of this review, such as a) provide information of relevance for refining the definition of UBW; b) provide information about factors that may constitute causes of UBW in surgical divisions c) to outline possible consequences of UBW d) to outline the prevalence of WUB in CT surgical divisions e) to summarize effective intervention measures and f) to contain data about physicians, nurses, operating room staff, trainees, and male and female surgeons. Specific reasons for excluding articles from the search were: lack of relevance to the review's aims. The results of the publications selection are presented in Figure.



* Some of the included papers were relevant to more than one of the proposed questions

Article selection according to inclusion and exclusion criteria

RESULTS AND DISCUSSION

Of the 89 publications selected by the first author for in-depth study, there were 6 systematic reviews, 17 narrative reviews, 60 original studies (mostly surveys), 6 cases/expert opinions and one report which included narrative, systematic review and case study simultaneously. Considering that a significant part of the publications contributed to several review aims, we grouped key findings of all relevant publications in four areas: cardiothoracic surgery, general surgery, medicine, and psychology.

Terminology and definitions of UBW

The review revealed that UBW in medicine is a concept that covers a wide variety of behaviours. Shapiro emphasizes that it may be criminal acts, such as direct harm or sexual assault, or involve actions that are not criminal in a legal sense but are destructive to the professional culture, such as sexual harassment, discrimination or bullying [10]. Crebbin and colleagues suggest that UBW may take the form of distinct signs of discrimination or bullying, or only sexual harassment, or maybe a combination of all

these types of UBW at the same time [11]. However, Halim and colleagues in the systematic review of 32 studies showed that there is no universally agreed definition of what is defined as bullying, discrimination or harassment because of considerable heterogeneity of demographical, geographical and cultural differences [12]. Moreover, the authors agree that such behavior is subjective for evaluation, and can be perceived differently by individuals even in the same team [12, 13, 14, 15]. The review of UBW cases in 12 publications made it possible to divide most of the negative actions into overt and covert actions [4, 6, 16-25] which are summarized in Table 1.

Table 1

Examples of overt and covert unprofessional behaviour by a cardiothoracic leader towards other colleagues

Overt actions	Covert actions
Hostile or rude tone during clinic meetings, in front of patients, or the operating room	Ignoring questions or requests during a work meeting, or not paying attention to professional advice and mentoring
Tantrums when debriefing a surgeon about professional errors	Unreasonable exclusion of other surgeons from the operating room
Physical actions include shaking on the shoulders, pushing in the corridor, throwing, or breaking medical instruments	Unreasonable exclusion of experienced and skilled surgeons from the position of chief surgeon
Verbal threats to end a subordinate's surgical career	Restricted admission to professional meetings owing to failure to notify in advance
Offensive statements, for example, “With your crooked hands, you will not be able to become a real surgeon”	Jokes with sarcastic undertones about current surgical readiness and future career success
Offensive comments or jokes about female surgeons, such as saying that a female surgeon has hormonal mood swings or is more concerned about her personal domestic tasks during work hours	Disparagement of professional achievements, and overwhelming emphasis on shortcomings and mistakes
Sarcasm related to ethnic, religious, or cultural differences	Verbal hints about a more successful career in another institution, or re-profiling from a surgical specialty to a therapeutic one
	Sexual pressure, hints, harassment

For example, jokes in which doctors and nurses may support negative stereotypes about specific roles in the team – such as the notion that being a female surgeon and having a family are incompatible – are prevalent [23, 26]. However, a study by Kawase and colleagues found that 61% of female surgeons were married and 47% had children [27]. In addition, Lewis argues that the awareness of being a victim of UBW may not be instant, but maybe dependent on personal experience or information provided by colleagues [28], hence not based on this more objective definition. Odell and colleagues noted that trainees were often unwitting facilitators of offensive behaviour because they lacked the confidence to speak up and feared confrontation [29]. Thus, although different general definitions of UBW such as discrimination, bullying and harassment are in place, their implementation in the professional community may face issues related to the subjective perception and interpretation of the situation by the initiator and recipient.

Prevalence

The review revealed that UBW in medicine is a problem which occurs in many countries and among many medical specialities, including nurses and students [4, 30-36]. For example, Gianakos and colleagues in the systematic review of 25 studies which included 29,980 surgical residents from the USA, Australia, France, Canada and South Africa found that 63% experienced bullying, 43% experienced discrimination and 27% experienced sexual harassment [37]. In addition, Halim in the systematic review of bullying showed the highest level of bullying in the surgical team was reported in the United Kingdom (53.8%), followed by Australia (49.3%) and China (44.6%), with the lowest level in Japan (27.6%) [12]. A study from Saudi Arabia presented a more varied array of data, with signs of bullying in the surgical team ranging from 30.3% to 66.2% [30]. Overall, mostly underrepresented minorities in CT surgery experienced gender-based discrimination

and/or sexual harassment at the workplace [7, 34, 38, 39]. Men, especially those in leadership positions, are the most frequently reported initiators [11, 40, 41]. Unfortunately, not only are female cardiac surgeons victims of colleagues' UBW, but female anesthesiologists who work in CT surgical teams also report verbal humiliation [22], such as sarcasm or unpleasant jokes [23]. Among studies which included CT surgeons, the prevalence of different types of UBW varies significantly from countries. Thus, the rate of discrimination varied from Australasia (15%) [11] to the United States of America (91%) [34]; sexual harassment varied from Australasia (4%) [11] to the United States of America and the United Kingdom (81%) [7]; Bullying varied from Australasia (49%) [11] to the United Kingdom and the Republic of Ireland (55%) [42]. Table 2 presents more studies of UBW that include data about CT surgical divisions.

Table 2

Studies of unprofessional behaviour that included the cardiothoracic surgical specialization

Author	Country	Gender	Results
Pompili C. et al. (2022) [43]	EU	F	Discrimination 67%
Ceppa D.P. et al. (2020) [7]	USA, UK	F M	Sexual harassment 81% Sexual harassment 46%
Freedman-Weiss M.R. (2020) [8]	USA	M, F F	Sexual harassment 48.9% Sexual harassment 70.8%
Clements J.M., et al. (2020) [42]	UK and Republic of Ireland	M, F	Bullying and undermining behaviour 55%
Seemann et al. (2016) [5]	Canada	F	Discrimination 41%
Crebbin W. et al. (2015) [11]	Australasia	M, F	Discrimination 15% Bullying 49% Harassment 37% Sexual harassment 4%
Bruce et al. (2015) [34]	USA	F	Discrimination 91%

Factors contributing to UWB

Some authors have suggested that bullying in medicine is as old as the profession itself [44]. Relatedly, Pei and Cochran have suggested that successful surgeons who personally experienced bullying from their supervisors may have learned that such behaviour is the only effective form of interaction/communication [17], thus perpetuating the problem across generations of surgeons. At the same time, there is a misconception among those who have completed their residency that this culture is acceptable in medicine [45], as exemplified by Taylor-Robinson and colleagues, who state that trainees may think that if they want to learn something, they need to put up with bullying, ignore it, and continue to work [4]. Moreover, Albuainain and colleagues showed that surgical residents generally believe that if they make an official complaint, this is unlikely to change anything [30]; instead, they may have a fear that such a complaint will make the situation even worse [46, 47] because when you complain, you become a problem for the organization [4]. Thus, a probable explanation of some types of UBW may be that both division chiefs and trainees expect and accept UBW as part of the professional culture behaviour and "tradition." Another significant cause of UBW in surgical teams, which was presented in the publications, was the hierarchical nature of one's relationships with colleagues [35, 48, 49, 50, 51]. Sexton found that the hierarchical relationship provides the most effective platform for communication in high-stress environments such as CT surgery or aviation [48]. In addition, Rosati and colleagues emphasized that the CT chief surgeon is usually on top of the hierarchical pyramid, combining the role of a surgeon with the head of a specific program, department, or hospital [52], and consequently has a high status and influential authority. Campos and colleagues stated that disruptive behaviour occurred more frequently between higher and lower hierarchical positions, such as those of surgeons and nurses. They argued that verbal aggression had various

causes, for example, a lack of supplies or equipment failure, errors in team-member performance, and communication problems [49]. Hsiao and colleagues found that the hierarchical relationships inherent to medical training facilitate sexual harassment [50]. Sexton and colleagues emphasized that lower-status team members may suffer from low efficacy, underestimate their contribution to the work, and feel less psychologically safe than higher-status team members, such as surgeons [48]. Furthermore, Sexton revealed that more than 50% of respondents reported that they found it difficult to discuss their mistakes openly; 76% of staff in an intensive care unit reported that many errors are neither acknowledged nor discussed because of their potential influence on personal reputations [48]. In addition, some authors noted that UBW was highly correlated with high-stress work environments [20, 53]; however, medical staff are more likely than aviation staff to deny the effects of stress and fatigue on medical errors or UBW [48, 54]. Benetis and colleagues showed that more than 60% of Lithuanian cardiac surgeons display signs of burnout [55]. Also, Amini and colleagues showed that burnout is often part of a vicious cycle, where bullying in the workplace threatens the victims' self-esteem, and leads to stress and a loss of resources [56]. Thus, UBW risk factors can be divided into three potential groups: 1) those that can and should be changed for the better – negative culture behaviour as a "tradition"; 2) those that can be changed only partially – high-stress work 3) and those that we cannot be changed but are important for understanding, like an influence of hierarchy in medicine.

Consequences

In 2008, the Joint Commission announced a Sentinel Event Alert that emphasized that organizations that allow or ignore UBW, are at risk of experiencing adverse patient outcomes [57]. Among 13,653 patients Cooper and colleagues found that patients whose surgeons had a higher number of coworker reports of UBW had a significantly increased risk of surgical and medical complications [58]. In addition, other groups of authors found that UBW among nurses was associated with poorer patient outcomes [33, 59]. Cochran and colleagues argued that UBW creates a snowball effect of increasingly frequent errors, because of impaired decision-making, attributable to staff members' decreased communication efficacy [60]. We found that UBW has negative consequences at the employee level, where UBW was associated with poorer employee psychological health, and increased intention to resign [32, 61, 62]. In addition, different groups of scientists found that those residents who during surgical training experienced bullying, discrimination and sexual harassment more often reported burnout, anxiety and depression [37, 63, 64, 65] sleep problems [66], suicidal thoughts and reduced well-being [63, 67, 68, 69]. Moreover, in the American national survey, Chow and colleagues revealed that more than 40% of CT surgeons displayed signs of depression [70]. We also identified significant consequences of UBW for the organization in general. Studies of organizational silence identified how feeling threatened can be a central factor for employees' unwillingness to speak up [18, 71, 72]. Nembhard and Edmondson noted that unwillingness to speak up has been associated with the lack of organizational change and a lack of safety and injustice culture [73]. Carter and colleagues found that in England among National Health Service staff UBW was associated with increased intentions to leave work [61]. In addition, Illing and colleagues showed heavy financial burdens for the National Health Service because of UBW [74]. Thus, three levels of UBW consequences are summarized in Table 3: patient level, medical employee level, and organizational level.

Table 3

Three levels of consequences of unprofessional behaviour at the workplace

Patient level	Medical employee level	Organizational level
Compromised patient safety and quality of care [59]	**Low job satisfaction and job retention rates [61]**	**Lack of safety, and injustice culture [73]**
Increased risk of medical error [60]	**Diminished respect for surgeons [60]**	**High level of employee resignation, turnover, or lack of motivation to continue working at such a workplace [75]**
Increased risk of surgical and medical complications [58]	**Interpersonal conflicts [20]**	**Heavy financial burdens [74]**
	Burnout and distress [37, 70]	
	Depression and suicidal thoughts [63]	

Interventions

In the review of UBW interventions, we found that all measures could be roughly divided into two approaches, such as reactive measures and proactive measures.

In response to increasing concerns about UBW in surgical divisions, male and female surgeons, and professional associations have launched special campaigns intended to eradicate UBW, such as #LetsRemoveIt [76], #UsToo [7], and the #TimesUp movement in health care [77]. The Royal Australasian College of Surgeons established an Expert Advisory Group, tasked with developing strategies to change the culture of bullying, discrimination, and sexual harassment [11]. The most frequent call to action is zero tolerance and reporting UBW cases. According to other data, directly mentoring female surgeons in CT surgical divisions is effectively supportive [14, 78]. Some groups of authors showed that monitoring or screening may help organizations maintain the awareness of UBW [79, 80, 81]. Although Crebbin and colleagues found that the conventional approach of formal reporting did decrease UBW somewhat, it may however not be a safe choice for the victim [11]. In contrast to active reporting about UBW cases, educational measures of increasing staff awareness of overt and covert UBW actions and potential consequences of UBW may be safer and increase employees' willingness to make changes in their work environments. For example, Meloni and Austin implemented a special program in a hospital, where the chief developed a written statement about all staff members' collective responsibility for eradicating UBW in the workplace. Also, they placed posters in the work areas to strengthen awareness of UBW. This program had a positive impact on eliminating bullying and harassment and on staff satisfaction [21]. Gostlow and colleagues showed, that a retrospective analysis of video data of an operating theatre simulation was effectively developed to identify how surgeons, from a range of experience levels, react to UBW cases in the operating room [82]. In addition, the Edmondson study of 16 operating cardiac teams showed that CT division chiefs who took an active role in directly and inviting other team members to speak openly could reduce status-based barriers to speaking up. She also noted that CT division chiefs who acknowledged their weaknesses and fallibility and emphasized the meaning of teamwork could decrease the status barriers in the team, and helped to create a sense of psychological safety [72]. Moreover, focus-group interventions that provide workshops for teaching nurses and surgeons emotional intelligence [83], stress management strategies [84], conflict management skills [85], 86] may improve nontechnical skills, such as cognitive skills and empathy for colleagues at the workplace [87, 31, 88]. Several resources recommended the use of teambuilding activities to prevent or eliminate cases UBW [19, 89, 90, 91, 92, 93]. The importance of a proactive approach is emphasized by authors as more constructive. Groups of authors stated that staff need to be aware that the boundaries of what is offensive behaviour are sometimes subjective and unclear, and in consequence, healthcare organizations should expect instances of UBW, look for it, and address it before problems escalate and result in negative outcomes [74, 94, 95]. Einarsen and colleagues argue that policies should be formulated before cases of UBW occur, as this will prevent the occurrence of UBW. They also stated that policies should set standards of acceptable behaviour and set out the procedure for complaining about UBW [13]. In addition, Dimarino showed that a written agreement concerning acceptable and unacceptable rules of conduct, signed by each of an organization's employees, may also be an effective solution to UBW, where organizational policies against UBW may moderate the relationship between interpersonal injustice and workplace aggression [96]. Moreover, Illing and colleagues, emphasized that policies should support a new set of values, and highlight an awareness of the potential consequences of UBW [74]. Einarsen and colleagues stated that social reconstruction of group values that are shared by individuals in a given setting may help to achieve agreement in determining what patterns of behaviour would be regarded as UBW by almost everyone [13]. Thus, shared trust regarding UBW-case appraisal helps to focus attention on intervening at the organizational level, rather than at the victim level. Association of Surgeons in Training published organizational- and department-level recommendations that focus on creating safe, positive, and supportive environments for work and learning [97]. However, if the culture is not inclusive nor psychologically safe, it may be difficult to share subjective experiences of UBW with colleagues.

Thus, the most recommended interventions in the reactive and proactive approach included four foci: 1) educational measures to raise awareness of the causes and consequences of UBW; 2) developing safe methods of discussing UBW cases; 3) a written agreement signed by all employees of an organization, concerning acceptable and unacceptable rules of behaviour; 4) workshops for training in nontechnical skills.

CONCLUSION

1. This review summarized the ongoing debate regarding the complex task of unambiguously defining unprofessional behaviour in the workplace. We showed that definitions of unprofessional behaviour

in the workplace vary considerably, depending on what types of behaviour are unprofessional behaviour in the workplace. Even across different studies labelling unprofessional behaviour in the workplace differently, scientists indicate a consensus regarding unacceptable behaviour such as bullying, discrimination, and sexual harassment. This literature review reveals a high level of unprofessional behaviour in the workplace is experienced by CT staff at the workplace. Various factors may provoke unprofessional behaviour in the workplace, such as psychosocial challenges being part of the bad professional culture, the hierarchical type of relationships and a high-stress environment. Unprofessional behaviour in the workplace may manifest in overt and/or covert actions and have a negative impact on patients, employees, and the organization. Effective interventions are proactive interventions. Division chiefs' inclusiveness in unprofessional behaviour in the workplace discussion is crucial for intervention success and for creating a positive and safe work environment.

2. Taken together the current review supports the following recommendations for CT leaders:

- *Develop the ability to pay attention.* During problem-solving meetings, try to shift perspective by radically changing your personal experience, for example, if you are a male surgeon, consider it from the perspective of a nurse or a female surgeon, and vice versa. Invert the case of UBW, just to consider all potential victims' feelings.

- *Focus on preventive educational interventions.* Try to find time during a "peaceful phase," before UBW cases occur in your organization.

- *Elaborate formal policies together with representatives of all hierarchical levels.* Encourage the free exchange of information, and constantly ask employees if they perceive UBW from colleagues.

- *Write a normative commitment.* A code of conduct should be written, and all staff must sign this, regardless of their status.

- *Proactive problem screening*. Monitor organizational data concerning bullying, discrimination, harassment, the safety of the work environment, illness, turnover, and burnout.

Limitations to this literature review. The selection criteria for the article's publications were not as stringent as when conducting a systematic review. The data tended to be descriptive and to apply cross-sectional searches. We have included a limited number of words associated with UBW; of course, such a list could be much larger. We focused our attention in the vast majority on studies devoted to the relationship of leaders and chiefs with their subordinates, and we did not highlight the phenomenon of group UBW against individuals or equal colleagues by status.

Contributors:

Sydorenko A.Yu. – conceptualization, methodology, data curation, writing original draft

Spindler H. – review, editing and supervision.

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