

Climate change: addressing harassment, abuse, mistreatment, and discrimination in medical education

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Goals and objectives

As a result of this presentation, participants will:

- Identify major categories of harassment, abuse, mistreatment and discrimination
- Be able to address the consequences of HAMD on the learner and learning environment
- Apply simulated scenarios to training in their settings
- Discuss faculty development opportunities to affect change in medical education culture

Culture

There are these two young fish swimming along and they happen to meet an older fish swimming the other way, who nods at them and says,

“Morning boys. How’s the water?”

And the two young fish swim on for a while, and then eventually one of them looks over at the other and goes,

“What the hell is water?”

- David Foster Wallace, *This is Water*, 2009, Little Brown and Co. NY

Introduction to our setting

6 hospitals in system, newly merged as network

GME programs: 2010 one program, FM residency, 24 residents, 10 core faculty

2019 6 programs, 63 residents, 30 core faculty

UME program: 2010 6-30 medical students each month

2019 120-200 medical students each month

Culture of education: proudly the “Un-University” organization

Historical mistreatment at medical school (Lubitz, 19--) with many grads in our network

Private practice and fierce independence

Network of multiple hospitals and practices

Our Culture of Education

- Learning environment perceived by students to be friendly
- Individual events still merit concern
- Culture of medical education contributes to distress, distrust and not speaking up
- Network initiatives about physician wellness parallel AIAMC initiative for GME
- ACGME survey consistently below national norm on “expressing concern” (Institutional average 53%)
- Until new medical school matriculated first class in 2015, one medical school in state
- High incidence of medical student abuse in clinical setting at primary medical school
- Many medical staff came from that environment

HAMD: Harassment, Abuse, Mistreatment and Discrimination

- Course of conduct which annoys, threatens, intimidates, or puts a person in fear of safety
- Sexual harassment
- Quid pro quo
- Hostile work environment
- Comments on appearance
- Bullying
- Psychological harassment,
- Cyberbullying
- Retaliatory
- Physical abuse, sexual assault
- Critical demeaning feedback
- Misjudgment of performance
- Racial, Gender, Age, Ethnic ,Religious, Disability: Academic discrimination in hiring, promotion, evaluation

Handout on HAMD (identification)

Types of inappropriate workplace behaviors in medical education:	Example
Verbal abuse, bullying	You are the worst person on this team
Public humiliation	I can't believe you didn't know that
Name calling, nicknames	Calling someone "Legs" who is really tall
Belittling	I don't think you can manage this work
Academic abuse	Why don't you write a ten page paper and present it to us at morning report?
Taking credit for your work	I will present this for us to our preceptor tomorrow.
Being given tasks for punishment	You need to learn this material. Go ahead and present to us all tomorrow.
Threats	Do you want to pass this rotation?
Physical abuse	A patient who is angry hits a nurse who is trying to adjust her IV.
Political questions or innuendo	You probably voted for (her/him), right?
Racial/ethnic/religious comments	You are one of "those" people. We really do need a wall.
Sexual comments	You don't look like you would not have a boyfriend.
Sexual advances	I bet you are a lot of fun outside of work
Being passed over for reward, promotion	You are not ready for the kind of work we will need from a chief resident.
Threat to career, grade or reputation	I don't think you know how important it is that I'm happy with your work this month.
Gender discrimination	Women should probably not do this work.
Psychological intimidation	Are you sure you can do this? It's a pretty hard procedure.
Age based discrimination	You don't look old enough to be a doctor

Incidence and prevalence of HAMD

A review of the literature supports a high frequency of abusive interactions during school and residency training, with many by patients.

Over 50% of medical students report at least one instance of personal experience of mistreatment.

75% indicate observation of events which constitute mistreatment.

Faculty have had experiences which contribute to burnout. . .and also inform how they model and teach.

GME and medical group setting new expectations

- Acceptance of network standards
- Inclusion in physician compact
- Medical staff and physician leadership intervening in behavioral violations
- Termination (no tolerance)

Harassment and discrimination in medical training: A Meta-analysis

Table 2

Comparison of the Prevalence of Harassment and Discrimination Among Medical Students and Residents, According to Studies Identified in a 2011 Systematic Review of the Literature

Type of harassment	No. studies		Sample size		Mean		95% CI	
	S	R	S	R	S	R	S	R
% Harassment	30	19	26,579	11,193	59.6	63.4	49.2–68.0	53.6–73.2
% Verbal abuse	16	12	18,865	9,867	68.8	58.2	56.6–81.0	45.5–70.9
% Gender discrimination	10	3	4,922	1,315	49.8	66.6	34.6–65.0	58.7–74.5
% Academic	10	4	3,062	2,257	39.5	27.7	26.8–52.2	6.0–49.4
% Sexual	25	10	22,316	7,077	33.3	36.2	27.2–39.4	19.8–52.6
% Racial discrimination	7	3	16,121	3,261	23.7	26.3	13.6–33.9	24.2–28.3
% Physical	15	10	18,790	6,760	9	28.9	7.0–11.1	15.9–41.8

Abbreviations: CI indicates confidence interval; S, medical students; R, residents.

GME study, Canada, 1996

- Psychological abuse was reported by 50% of the residents.
- Some of the respondents reported **physical assault**, mostly by **patients and their family members** (14.7% reported assaults by male patients and family members, 9.8% reported assaults by female patients and family members),
- 5.4% of the female respondents reported **assault** by male supervising physicians.
- Discrimination on the basis of gender was reported to be common and was experienced significantly more often by female residents than by male residents ($p < 0.01$).
- Ten respondents, all female, reported having experienced discrimination on the basis of their sexual orientation. Most of the respondents experienced sexual harassment, especially in the form of sexist jokes, flirtation and unwanted compliments on their dress or figure. On average, 40% of the respondents, especially women ($p < 0.01$), reported experiencing offensive body language and receiving sexist teaching material and unwanted compliments on their dress.
- Significantly more female respondents than male respondents stated that they had reported events of sexual harassment to someone ($p < 0.001$). The most frequent emotional reactions to sexual harassment were embarrassment (reported by 24.0%), anger (by 23.4%) and frustration (20.8%).

Residents' experiences of abuse, discrimination and sexual harassment during residency training. McMaster University Residency Training Programs. [D.J Cook](#), [J.F Liutkus](#), [C.L Risdon](#), [L.E Griffith](#), [G.H Guyatt](#), and [S.D Walter](#), CMAJ v 154(11) 1996

IU SOM

- Survey of IUSOM third year clerkships
- Identified forms of harassment and abuse, including physical abuse of students by faculty
- High prevalence reported by trainees
- Consequences for physician wellbeing: depression, anxiety, insomnia, alcohol, drugs

Lubitz, RM; Nguyen, DD. Medical student abuse during third year clerkships. *JAMA*, 1996, 275: 414-416.

We started to work on the culture:

- Poll Everywhere to get a sense of incidence, prevalence
- Normalize issues in medical education
- Begin discussions of boundary violations using vignettes
- Facilitate discussion of differences among faculty in defining “unacceptable”

Sample POLL EVERYWHERE with faculty and residents

Have you or a colleague ever:

- Been touched inappropriately
- Been called nicknames related to your appearance
- Been asked sexual questions in the context of training
- Been made to feel uncomfortable in a professional setting
- Been bullied

SAMPLE POLL EVERYWHERE: Have you or a colleague

Been asked to do personal favors for a supervisor?

Been asked to do unethical behaviors for a grade or evaluation?

Been asked to falsify documentation on a patient?

SAMPLE POLL EVERYWHERE questions for faculty and residents

Have you seen a patient reject care because of:

- Race, ethnicity or culture?
- Gender or gender identity?
- Age?

HAMD simulation: Speak up!

During orientation with our interns we do OSTE's to teach about patient safety.

June 2018: Harassment SIM case and related teaching session about how to respond and speak up

14 new interns went through the SIM and teaching session.

Simulated patients were in role as faculty and nurse.

Residents worked as team to participate or offer suggestions about response to others.

Residents found simulation valuable and we are now using with all incoming residents

Teaching the desired behaviors: speak up sim

- INSERT video here

Relational communication tools: examples

Intention:

To a patient: “My intention is to help you take better care of yourself, not to criticize you.”

To an evaluator: “My intention is to do the best I can on this rotation. . . .”

Assertive (not aggressive) reply

Use common goals for identifying desired behavior: “I know we both want the best for this patient, so...”

Limit-setting: “I am unable to give you the medications you expect, but I will do everything I can to help you with your pain”. ? Do we want to come up with a resident example?

When it’s not about you, but another person: “I cannot comment on my colleague’s performance, but I am happy to help him/her do better.”

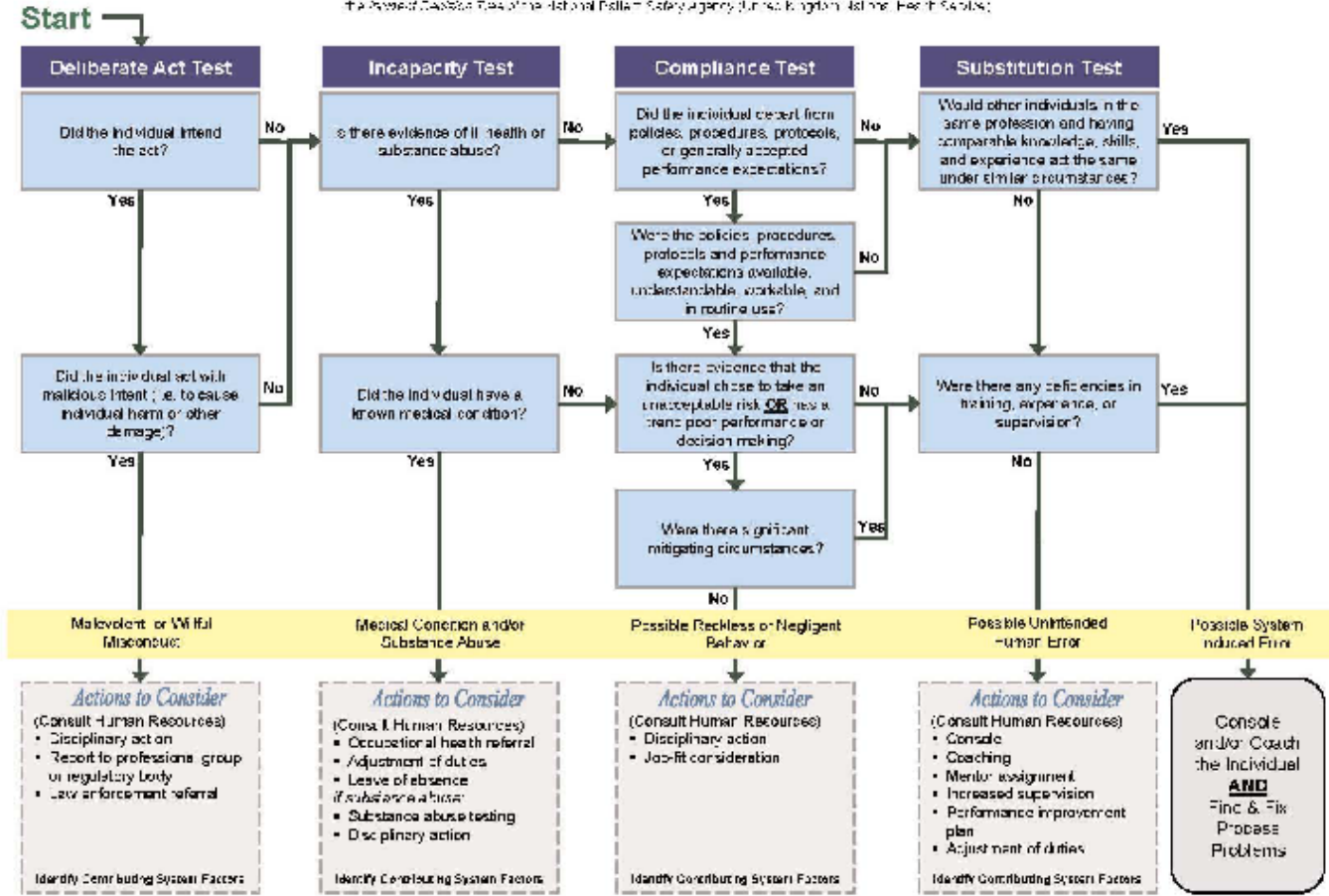
Appeal to common values: “You know that’s not how we want to behave as a group”

We Can Differentiate



Performance Management Decision Guide

Adapted from the *Health Care Worker Decision Making: The Organizational Implications* book, published by the National Patient Safety Agency, London, England, 2004. Health Services.



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Our challenge

The single greatest impediment to error prevention in the medical industry is “that we punish people for making mistakes”

Lucian Leape, MD
Professor, Harvard School of Public Health
Testimony before congress on Healthcare Quality Improvement

Just Culture defined...

Just Culture creates an atmosphere of trust in which people are encouraged to provide, and even rewarded for providing, essential safety-related information but in which they are clear about where the line must be drawn between acceptable and unacceptable behavior.

James Reason

Managing the Risks of Organizational Accidents (1997)



Speaking Up for Safety Using ARCC

Use the lightest touch possible...

Ask a question

Make a **R**equest

Voice a **C**oncern

If no success... Use **C**hain of Command

A Community Safety Phrase

“I have a **concern...**”



Non-Compliance

A person knows the rule, has the skill and ability to perform according to the rule,

makes a choice to disregard the rule

Usually, a *conscious but not malicious decision*, made after weighing the pros and cons, that it is better choice to not comply

Also known as *risk-taking*

What we are doing:

- Focus on discussions with faculty and residents (boundary violations)
- Wide variation among faculty by specialty
- Lack of true acknowledgment out loud about violations in our midst
- Not a lot of safety among faculty (yet) to discuss own med ed experiences
- Need some physician leaders who are healed enough to discuss their own experiences and their cost to well-being
- Concerns about loyalties among faculty and residents
- Versions of reality, confidentiality with HR and legal issues



EXAMPLES FROM OUR NETWORK

Retribution and Fear

A resident is working on the inpatient service halfway through intern year.

Patient on the service has been put onto suicide precautions. Despite orders an intern observed a nurse giving patient a disposable razor to shave.

The intern thought this was inappropriate and filled out a MIDAS report based on this observation.

Two days later the same nurse was working again, and she yelled at the intern in front of the treatment team for reporting her. She stated she wished the intern confronted her personally instead of reporting it.

Scenario one

- Faculty informally conversing with resident in hallway.

“I notice you colored your hair. Does the rug match the drapes?”

Scenario two

- Faculty member giving feedback at morning report, in front of peers, to resident

“Do you think you chose the right specialty? You seem to be struggling a lot with pretty basic procedures.”

Scenario three

- Colleague to colleague in hallway:

“Are you pregnant? Your boobs look bigger.”

Scenario four

- Faculty preceptor to nursing staff in outpatient clinic

“Do you mind if Dr. X practices his pelvic exam skills on you? He needs to get his numbers up.”

Breaking the cycle: What does it take?

- Awareness and observation
- Discussion and holding accountable
- Personal development and self-awareness
- Cultural commitment
- Speaking up becomes acceptable
- Non-retribution in culture
- Support across organization

Parallel process

- Behavioral team wanted to start training about sexual harassment and abuse
- Faculty not ready, have to start with speak up and patient safety
- Must have psychological safety to support culture changes
- Faculty cannot address “culture” without guilt about releasing residents from training, not providing enough “safety” abuse, esp sexual abuse, own experiences
- Faculty development about who owns, who is accountable

What are you doing in your organization?

Culture of medical education: What can we as GME community do?

- Become aware of our own biases
- Notice our own behavior
- Reflect to others when we treat patients, peers or others as *less than*
- Raise awareness of the culture we WANT in our organization
- Partner with culture change in network
 - Diversity council
 - Ethics council
 - HR and training initiatives

Handouts for attendees

- Simulation description
- Cases
- Reference list
- Handouts given to residents illustrating HAMD examples
- Safety decision tree