

Virtual Mentor

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The Problem of Mistreatment in Medical Education

From the Editor

- To Bully and Be Bullied: Harassment and Mistreatment in
Medical Education** 155
Ajay Major

Educating for Professionalism

Ethics Cases

- Pimping: Report or Do Nothing?** 161
Commentary by Paul Burcher
- Professionalism versus Antiharassment in Student Evaluation** 165
Commentary by Howard Brody
- Advising the “Gunner”: The Student with Noncognitive
Learning Difficulties** 169
Commentary by Kimberly A. Kilby

The Code Says

- AMA Code of Medical Ethics’ Opinion on Sexual Harassment
of Medical Students and Residents** 176

Medical Education

- Role Play in Medical Education to Address Student
Mistreatment** 177
Alison M. Heru
- The Socratic Method and Pimping: Optimizing the Use of
Stress and Fear in Instruction** 182
Robert C. Oh and Brian V. Reamy
- An Abuse-Free Medical School Environment: An Ethical
Imperative** 187
Joyce M. Fried and Sebastian Uijtdehaage
- Feminist Learning Strategies in Health Professions Education** 192
Nancy J. Michela

State of the Art and Science	
Measuring Mistreatment: Honing Questions about Abuse on the Association of American Medical Colleges Graduation Questionnaire	196
Brian Mavis	

Law, Policy, and Society

Policy Forum	
Anonymous Surveys to Address Mistreatment in Medical Education	200
Georgette A. Dent	

Medicine and Society

Moving Away from Hazing: The Example of Military Initial Entry Training	204
Gia A. DiRosa and Gerald F. Goodwin	

History, Art, and Narrative

Images of Healing and Learning	
The Hanging Medical Student: Sacrifice and Authority in Medical Education	210
Tripp Leavitt	

Medical Narrative

Teaching by Humiliation—Why It Should Change	217
Jonathan Belsey	

Resources

Suggested Readings and Resources	220
About the Contributors	232

Upcoming Issues of *Virtual Mentor*

April: Third Parties in the Clinical Encounter	
May: Ethical Issues in Geriatric Care	
June: Intersections of Race, Ethnicity, and Medicine	
July: Ethical Issues in the Physician-Athlete Relationship	

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FROM THE EDITOR

To Bully and Be Bullied: Harassment and Mistreatment in Medical Education

In 1990, pediatrician Henry K. Silver first documented the rampant problem of medical student mistreatment in a study reported in *JAMA*, which found that 46.4 percent of students at one medical school had been abused at some point during medical school; by the time they were seniors, that number was 80.6 percent [1]. In the 24 years since that landmark study, medical educators have invested considerable resources in qualifying and quantifying the problem to address it appropriately.

The conversation around student mistreatment reached a crescendo in 2012 with the publication of Pauline Chen's article "The Bullying Culture of Medical School" in *The New York Times* [2], a poignant admission of the problem and the first major public acknowledgment of the bullying culture by a member of the medical profession. Using her personal experience, Chen's article elucidates the significant morbidity associated with medical student abuse. Medical students who report mistreatment were more likely to experience depression, alcohol abuse, low career satisfaction, low opinion of the physician profession, increased desire to drop out of school, and even suicidality [3-5].

Despite increased awareness of the problem, attempts at ameliorating medical student abuse have been largely unsuccessful. The Association of American Medical Colleges graduation questionnaires (AAMC GQs) from 2012 and 2013 reported student mistreatment rates of 47.1 percent and 42.1 percent, respectively [6, 7], similar to the 46.4 percent rate Silver found at a single institution in 1990. And, unfortunately, public humiliation and verbal abuse, the most common forms of mistreatment [8], are at similar or higher levels now than they were in 1999 [9].

Looking to other countries has not yielded models for addressing this problem. Studies from medical schools across the globe have corroborated the findings of American studies, with schools in Chile [3, 10], Finland [11], Israel [12], Japan [13], Pakistan [14-16], Germany [17], Saudi Arabia [18], Nigeria [19], and Canada [20] reporting medical student abuse. These studies have identified a similar resistance to eliminating the problem, even with an understanding that mistreatment is a "universally wrong tradition in medical culture" [21].

The question that this issue of *Virtual Mentor* seeks to answer is: what is medical student mistreatment and how much, if any, is appropriate to the learning environment? The question is complicated by disagreements about the definition of mistreatment, the sources of mistreatment, and whether its effectiveness as a teaching tool outweighs the harms it causes and the ethical violations it entails.

Defining Mistreatment

Numerous studies have demonstrated that attending physicians, residents, nurses, and students define abuse differently, with further variability based on specialty, gender, and ethnicity [22-24]. The definition is complicated by the “hidden curriculum” of professionalism, which dissuades and even punishes students for talking about abuse they witness [25]. As Richardson and colleagues astutely state: “Marked variability in the students’ perceptions of mistreatment within departments suggest that a variety of approaches will be required to improve the medical training environment” [26]. It is clear that the variety of approaches attempted to date has not sufficed to curb mistreatment. In this issue of *VM*, Brian Mavis, of the Association of American Medical Colleges graduation questionnaire advisory committee, discusses the committee’s efforts to standardize statistics on mistreatment by focusing questions on whether particular events have occurred, rather than on the student’s perception of whether or not those events qualify as mistreatment.

What Does Mistreatment Stem From?

Student mistreatment is generally understood to stem from the teacher-learner power differential inherent in the hierarchy of medical education, which leads to a “cycle of abuse” in which medical students who are mistreated go on to become doctors who mistreat other medical students [27-29]. Kassebaum brilliantly characterizes this cycle as a “transgenerational legacy” that indoctrinates physicians-in-training into a culture of cynicism and abuse [8]. This culture becomes part of the “hidden curriculum” in medical education which hinders interpersonal communication and negatively impacts patient care [8, 30, 31].

Medicine can learn from the US military’s alteration of training methods to eliminate abuse of new recruits, discussed in this issue by Gia A. DeRosa and Gerald F. Goodwin. In their piece for this issue, Joyce M. Fried and Sebastian Uijtderhaage discuss the UCLA David Geffen School of Medicine’s ongoing attempts to interrupt the cycle of educational mistreatment through its Gender and Power Abuse Committee. Nancy J. Michela writes on the use of feminist teaching practices to reduce hierarchy and empower students in nursing education.

Some believe that structural pressures in health care are responsible for mistreatment by rewarding abuse and punishing professional behavior. Brainard posits that students who cut corners, cover up minor errors, and unconditionally agree with superiors are seen as efficient and timely, characteristics that are highly valued by the burdened health care system. These students are more likely to be seen as professional than students who display honesty and respect for patients [31]. This environment rewards medical students who act as professional and ethical “chameleons” [31]. In her case commentary, Kimberly A. Kilby identifies ways in which the evaluation and feedback systems used in medical education could be altered to discourage, rather than reward, competitive behavior.

Effective, but Morally Defensible?

The dominant teaching culture in medicine is confrontational and challenges the knowledge and learning capabilities of students, and teachers can easily cross the line into being verbally abusive and humiliating their students. However, many medical students and physicians argue that this traditional model of teaching in medical education better prepares medical students for the clinical environment and is an effective pedagogical tool. As Wiebe asserts, “most would agree that a certain amount of intellectual confrontation can be constructive” [32] in medical school. The age-old practice of “pimping,” he says, forces students to be prepared and think on their feet. Intimidation and abuse have been cited as valuable in the education of medical students, including by medical students themselves [10, 33]. Aref-Adib writes “Through this Socratic method of teaching, teachers are wearing us down, exhausting us until our thoughts are clarified and any faulty reasoning is exposed” [34].

Ultimately, however, it is clearly the medical profession’s duty to provide an academic environment that exemplifies the morals it wants trainees to embody and does not require trainees to withstand abuse in the name of learning. As a previous *Virtual Mentor* author puts it, “medical educators have a moral imperative to create a culture of caring and respect in the field” [27]. In this issue, Jonathan Belsey argues that, despite the success of aggressive teaching methods—including those he himself used to teach students on the BBC program *Thoroughly Modern Medic*—they are morally unjustifiable and we must seek better alternatives.

Solutions?

Several of this month’s authors argue that, by better understanding the experience of being bullied, we can move towards effective solutions that teach professional behavior while preserving academic rigor. Pauline Chen speaks in this issue’s podcast about her article’s reception by the public and her experience with bullying as a learner and a teacher. Alison M. Heru takes up the use of role playing to promote understanding among instructors about the experience of the mistreated student. Georgette A. Dent emphasizes the importance of anonymous surveys for collecting accurate reports from mistreated students, so that instructors can understand how they affect students. Tripp Leavitt, a medical student at the Boston University School of Medicine, contributes and interprets artwork that explores the experience of sacrifice and careful navigation of authority that medical training requires.

Case commentators Howard Brody and Paul Burcher argue that mistreatment can be ameliorated by educators’ establishing and enforcing institutional policies against it and students’ reporting humiliating behavior. Robert C. Oh and Brian V. Reamy believe that on-the-spot questioning can be instructive and useful without being humiliating or abusive.

This issue seeks to bring together a diverse range of perspectives on the issue of medical student mistreatment and to serve as a launching point for future work on

curbing this pervasive problem. It is imperative that we do so for medical students, for the future of the profession of medicine, and for our patients.

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ETHICS CASE

Pimping: Report or Do Nothing?

Commentary by Paul Burcher, MD, PhD

Mark shuffled behind Dr. Powell, furiously writing out the LaFarge equation for estimating oxygen consumption on his clipboard. As usual, he had embarrassed himself while presenting the previous patient after forgetting to do the basic cardiac calculations before rounds. He promised himself he wouldn't forget it again.

Mark's pediatric cardiology clerkship, now only in its second week, had been the worst of his clinical years. Cardiology had never been his strong suit. During the first week, Mark's struggle with interpreting blood gas results and repeated confusion of VSD with ASD had made it apparent that he was the weakest of the five clerkship students.

Today, however, none of his peers were having luck with Dr. Powell's relentless pimping. Dr. Powell was a decent teacher, though his reliance on that particular teaching tool made every morning miserable.

"Mark, maybe you can do better than your colleague." Mark snapped to attention. Dr. Powell had begun questioning the group about the next patient. Mark was standing second in the line of students outside the room. His colleague to the left of him looked distraught, fumbling in his notes for the answer to the question he just missed. "Based on the echocardiogram, what kind of congenital defect should we be looking for?"

"Uh," Mark stuttered. He had viewed the imaging study for this patient before rounds this morning, but he was always terrible at septal defects. "Is it an ASD?" Mark answered tenuously.

"Jesus, Mark, have you learned *anything* in school?" Dr. Powell barked at the top of his lungs. "I can't believe you're even in the same class as these guys! At this rate, the only good thing I'll be able to do is fail you from this clerkship. Go the library and do *not* come back until you know what you're talking about."

Mark was stunned. Hadn't the other guy missed the same question? One of the corner of his eye, Mark saw his colleague's shocked expression turn into steeled discomfort as he suddenly faced forward. Dr. Powell stared at Mark expectantly. Taking the hint, Mark turned away and started towards the end of the hall as the pimping continued behind him.

Nurses at the charge station at the end of the hallway looked at him sympathetically; they had heard the tirade all the way at the end of the ward. Staring dejectedly at his feet and hating every stupid neuron in his head, Mark literally ran into his colleague Jarna on her pediatrics rotation, tripping over her neon orange clogs.

She put her hand on his shoulder, looked at him straight in the eye, and said, “Suck it up, dude. This is medical school.”

Commentary

Thomas Nagel, famous twentieth-century philosopher, writing about the ethics of war, not the pimping of medical students, formulated the rule that we should all be Kantians (he uses the word “absolutists,” but the thinking is the same) in our ethics, except when it is too difficult [1]. Let me first explain what Kant would advise, and then we need to ask whether his recommendation carries too heavy a penalty to be realistically expected.

Kant believed that the best way to determine the ethical choice in a circumstance is to do a thought experiment in which the behavior you are considering is universalized [2]. In other words, he asks that you ask yourself whether you can conceive of a world in which everyone *must* do what you are considering doing. Your one action would become as binding as a law of nature. So, he argues, lying is immoral by this standard, because if universalized it would be self-defeating: if everyone lied, no lie would be efficacious in achieving its desired end. Kant isn’t worried about the effectiveness of lying; rather, his thought experiment is supposed to help you determine whether your action is rational or not. Lying presupposes the existence of truth telling because you cannot deceive people unless they expect that you are telling the truth. But if lying becomes a universal law (everyone must do it), then no one would be able to believe anyone else; the law becomes self-defeating. Kant believed that looking at each decision in this way could help us make moral choices, and that such choices would affirm human dignity and make the world a better place.

How does Kant’s reasoning apply to this case? Mark has a simple choice—report the inappropriate, verbally abusive behavior or do nothing. Universalize both choices, and decide which leads to a world you would want to live in. Obviously, reporting the behavior promotes human dignity, whereas ignoring it places Mark’s grade in pediatric cardiology over the larger good of holding attending physicians accountable for their behavior toward medical students.

But if this part of the decision is easy, the second part is not. Must we always be good Kantians? Even though Kant is concerned with duties, not consequences, Thomas Nagel thought that sometimes the consequences of “doing the right thing,” from a Kantian perspective, were just too great to be upheld in every instance [1]. However, I don’t think that is the answer we should reach in this case. Mark is struggling in this clerkship, and, if Dr. Powell is his primary attending, his grade is going to be a problem whether he reports him or not. In fact, by reporting him, he

may be able to convince the dean to disqualify Dr. Powell's evaluation from his final grade. This is uncertain, so I am not arguing that he should report him out of self-interest, only that his interests may not actually be harmed by doing so.

The unknown aspect is how a report will be received. If Dr. Powell has already been reported as abusive, then Mark is likely to be believed and potentially protected from his report. If Mark is the first to report, things are less certain; he has no way of knowing whether his fellow students have also "done the right thing" and reported Dr. Powell. If they have, these reports will protect Mark from reprisal and move Dr. Powell one step closer to the door.

How are we to understand Dr. Powell's actions from within this same framework? I see only two reasonable possibilities, and they are both damning in different ways. The first option is that Dr. Powell believes that his teaching method is appropriate and efficacious. That is, embarrassing students is an acceptable way to "raise the bar" and encourage them to achieve. If he believes this, he has failed to educate himself regarding the evidence. Research has unequivocally shown that creating a hostile, intimidating environment is antithetical to learning skills and professionalism [3, 4]. So, if Dr. Powell believes he is a good instructor, he has failed to approach his duty as a teacher with the same evidence-based methods that he presumably applies to his specialty.

The other possibility is that he doesn't actually care about the quality of his teaching or, worse, that he enjoys making people subordinate to him feel bad. There are many possible variations here: he may be repeating bad behavior exhibited by his mentors while he was in training, he may enjoy his power and be a bit sadistic. The psychological analysis is, from an ethical perspective, unnecessary because his behavior hinges on a choice again to prioritize himself over the needs of his students. At best he is placing his clinical responsibilities over his teaching duties; at worst he is hurting others intentionally to satisfy some inner need or desire.

My point is that, although we cannot know his motives with any certainty, there is really no way to ascribe any positive motive to his behavior (unless you think it is positive to be willfully ignorant of the research on a major aspect of your profession). Kant argued that we should be cautious in our judgment of others and always seek to give them the benefit if the doubt. I believe the most generous reading of Dr. Powell's behavior is the first possibility: ignorance of the harm and ignorance of good teaching methods.

This leads us back to the question of what Mark should do and reinforces our original answer. If Dr. Powell has simply not paid attention to what constitutes good teaching, and once made aware of his failings would seek to improve, then Mark benefits both future students and Dr. Powell by making the dean of the medical school aware of his failings. But if Dr. Powell is actually working from darker motives or character flaws, then the sooner he is removed from a teaching position, the better.

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Related in VM

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ETHICS CASE

Professionalism versus Antiharassment in Student Evaluation

Commentary by Howard Brody, MD, PhD

You look up to see Dr. Syed walk into the attending physician lounge, throwing her long white coat on the table while collapsing onto the couch in one fluid, practiced movement. You haven't seen her looking this beat since you were emergency medicine residents together, and certainly not since you were both hired as tenure-track attending physicians.

"What's up?" you ask her.

"It's these students," she says, exasperated.

"What happened?" you ask.

She bolts upright on the couch, fists clenched at her sides. "I have students being rude to nurses, not preparing for rounds, being cavalier about the practice of emergency medicine," she barks. "People's lives are at stake! I absolutely cannot have that kind of behavior in the ER."

"So, write them up," you say nonchalantly. "This isn't the first time you've had bad students. The ER seems to attract them."

"That's the problem," she said, slumping back against the cushion. "I know I need to be pretty critical of these students, but after that student harassment workshop last month, it seems we can't say anything negative about them."

"But you just said patients were at stake," you interject. "They're just going to keep doing it if you don't say something."

"I know, I know," she admits, "but you saw what happened to Abena, yeah? A few legitimate critical comments about a student's performance—trust me; I worked with him before—and all of a sudden, off the tenure track. You think that's a coincidence?"

You doubt it was a coincidence. "So, what are you going to do? Using negative language in evals is unavoidable, especially with this batch of students."

"I don't know," she mutters. "This 'antiharassment' movement," she says, making air quotes with her fingers, "is getting out of hand. I feel like I've been muzzled."

How am I supposed to teach if I'm worried I'll lose my job or a promotion if I criticize my students?"

Commentary

We could discuss this case from the standpoint of what's most likely to happen in the real world, or we could address how a case like this might be handled in an ideal world. I'm going to adopt the latter approach to begin with, for I believe that there is value in reminding ourselves of what we're aspiring to, however difficult it might be to achieve in any given situation. There's too much danger that, if we only attend to the alligators, we may forget all about trying to drain the swamp.

As the intern Chuck says in the classic satiric novel about medical training, *The House of God*, "How can we care for patients if'n nobody cares for us?" [1]. This might suggest a general Golden Rule for medical faculty: treat the students in the same way you'd want them to treat the patients. This formula, however, is misguided; students are not patients and should not be treated in the same way. A better working rule is: *Do not treat the students in ways that you would not want them to treat patients*. If we want the students to treat patients attentively and with compassion, then we should not treat them in ways that lack those qualities.

There are two basic reasons for this rule. The first is that professionalism, and the related virtues of technical competence and compassion, are grounded in the core attitude that the patient's interests come before our own. If people are being mistreated by those who have power over them, they quickly fall into a defensive and self-protective posture. So students who are treated well and feel safe are more likely to behave professionally. There are plenty of naturally occurring barriers to professionalism; we don't have to invent extra ones. The second reason is that faculty serve the students as role models, and we cannot expect the students to attend to faculty as role models only when they are treating patients but not when interacting with the students, peers, or other hospital staff. The students will draw lessons about what's acceptable and what's expected from all the interactions they see the faculty engaging in. If they see the faculty treating anyone badly, the consequences are likely to be unfortunate.

We therefore have deduced a rule that faculty should not treat students badly. Faculty also have a duty to teach, and to assure that graduates have at least the minimal degree of professional behavior that makes them safe to go out in public and practice. At the end of the day, faculty are duty-bound to report and to attempt remediation for students whose professional behavior falls seriously short of the mark. This duty ought to be nonnegotiable. The question for us is what happens before the end of the day comes.

Professionalism is hard work. Few of us are naturally inclined consistently to put others' interests ahead of our own. Everyone has bad days. If we disciplined faculty for every deviation from the professional ideal, no matter how minor, there would soon be no one available to teach students or to see patients. Repeated, serious

breaches of professionalism demand firm action. What do more minor and temporary deviations require?

If physicians know other physicians who are usually very professional, and who suddenly start to behave in a less-than-professional manner, what would be a decent response? Certainly, asking what was the matter seems a good place to start. Rather than assume something irremediable, one would rather hope to identify a temporary stressor or other influence that could account for the undesirable behavior in an otherwise well-motivated person. Moreover, a warning to that person that the stress is producing suboptimal behavior obvious to professional peers is valuable feedback.

Is this a useful approach with students as well? Do the students fully realize how the faculty are interpreting the behavioral cues they present? Perhaps frank conversation with these students should precede the “writing them up” that the narrator in the case study recommends.

One reason that professionalism is hard work is that few of us naturally place others’ interests ahead of our own. Another reason is that our systems for providing health care—including academic medical centers—place more and more barriers in the way of those who try to prioritize good patient care and still get home to their families at a reasonable hour of the night. Faculty suffer today from numerous sources of stress, including ever-higher productivity targets, increasingly impersonal administrative structures, and more competition for research support. Students, too, face these sources of stress, as well as the increasing amount of loan debt needed to finish medical school. Professionalism ultimately requires that all within the medical system who aspire to professional values support each other in navigating these stressors and not turn against each other.

We don’t know how Abena, whom Dr. Syed refers to as her warning example, handled this set of pressures. Perhaps she did everything in an impeccable manner and still was victimized by an obnoxious student and an irresponsibly timid administration. Or perhaps she wanted to do the right thing but set about doing it in the wrong way. If the school has developed policies or precedents that discourage faculty from reporting real and serious concerns about students’ professionalism—if, as Dr. Syed alleges, the antiharassment pendulum has truly swung too far—the faculty must immediately confront the administration and demand improvements. On the other hand, if the school is trying to improve faculty members’ skills for addressing professionalism in a decent and responsible manner, the faculty should pay attention and not overreact. An ideal policy would provide training for faculty who wish to help students behave more professionally and then assure that faculty who pursue that goal in good faith are supported and not undermined.

Since both values—treating students humanely, and adequately policing the profession to protect the public—are important, there are no simple answers about how to balance them. But things can’t be good if dedicated teachers like Dr. Syed feel the way she does. Like the employee badgered by his boss who goes home and

kicks the dog, it is a human impulse to find somebody less powerful than you on whom to vent. The interns depicted in *The House of God* acted unprofessionally because their teachers abused them, and they took out their frustrations on their patients. Dr. Syed, perhaps, is at risk for becoming frustrated by all the stresses of the life of an academic physician in today's environment and taking it out on her students. Neither, of course, is a desirable strategy.

In today's increasingly complex world, as budgets get continually tighter, many medical school faculty feel that an "antiharassment movement" is sorely needed—one that protects the faculty from being harassed by their administrators and managers. (No doubt the managers feel that they need an antiharassment movement to protect them from the faculty; but that's another discussion.) If that's how the faculty feel, something ideally would be done about this, and we'd hope that the faculty themselves would take the initiative. We'd also hope in the process that the faculty would remember their obligations to the students and what effective formation of professional identity requires of both of them.

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ETHICS CASE

Advising the “Gunner”: The Student with Noncognitive Learning Difficulties

Commentary by Kimberly A. Kilby, MD, MPH

You’re barely one sip into your first cup of coffee of the day when the administrative assistant drops it on the desk with a thud: the looming stack of clerkship evaluations. It is going to be a very long day. When you became clerkship director of surgery, you expected the worst part of your job to be dealing with arrogant attending physicians. Little did you know that reviewing resident notes about medical students would be the bane of every rotation. The first file in the stack is flagged with a bright red sticky note. You grumble to yourself, knowing exactly what that means. You open the file.

Melanie, a third-year medical student, is currently in the middle of her surgery clerkship. You recall the chief resident saying she was “brilliantly talented” in a department meeting last week, a “future pioneering vascular surgeon, for sure.” Perusing the scribbled notes, you see that one resident reports that Melanie is an “anatomy expert” in the operating room during every procedure and “knows exactly how long to cut sutures.” An attending note states: “the most efficient presenter of patients I have ever known.” There is even a note from a patient: “Melanie was considerate, compassionate, and went out of her way to make sure all of our questions were answered, even when other students and doctors couldn’t answer them for us.”

Puzzled, you wonder why this file had the infamous red note.

As you thumb through the file, you find one note from a resident: “intense, rubs me the wrong way, doesn’t seem to know when to stop asking questions.” Another resident note calls Melanie a “gunner” with the “typical gunner problem of being almost unprofessional.” You start to find more negative notes, including one from an attending who was approached by Melanie’s clerkmates, saying that Melanie’s competitiveness made him and other students uncomfortable. According to that anecdotal report, Melanie subtly interrupts her peers to answer pimp questions and aggressively asks questions in front of students *and* residents to demonstrate her knowledge. Even in front of patients, she is continually competing with others to be the best. Another student reported that Melanie clearly treated the others as inferior students with her condescending demeanor and her hypercompetitive attitude. She was a gunner and her behavior was unprofessional, the student concludes.

As you spread all the notes out on your desk, you cannot find a description of a specific incident in which Melanie clearly stepped out of line to mistreat her fellow

students. The opinions on Melanie vary widely. On one hand, some of her colleagues feel attacked and mistreated by her. On the other, she is an excellent student with keen bedside manner and a promising career in surgery.

Commentary

This case addresses how medical educators should respond, if at all, to students like Melanie who present with behaviors representative of the “gunner.” “Gunner” is a slang term describing medical students who are so competitive and driven to succeed that they exhibit unprofessional behaviors toward their peers intended to make themselves appear smarter [1].

In the Association of American Medical College’s Medical School Graduation Questionnaire taken by graduating fourth-year medical students, the proportion of students who cited mistreatment from a fellow student was 14.6 percent in 2011 and decreased to around 6 percent in 2012 and 2013 [2-4]. In their commentary, medical students (at the time of writing) Brainard and Brislen proposed some possible reasons why students engage in unprofessional behavior [5]. They asserted that students are forced to bend their existing ethical principles in order to survive in the learning environment, adopting the explicit as well as the implied rules of the medical education hierarchy. They posit that “students become ‘professional’ and ‘ethical’ chameleons because it is the only way to navigate the minefield of an unprofessional medical school or hospital culture” [5]. In Melanie’s case, several classmates have brought forth concerns about “gunner” behavior, and the clerkship director is obligated to act.

The Role of the Clerkship Director

Clerkship directors are responsible for defining the expectations for students on the clerkship and facilitating the clinical learning environments that will optimally support meeting those expectations [6]. They often must depend on evaluations provided by their faculty peers and more junior faculty to assess each student adequately. Frequent communication is an important avenue for assessing each student in the clerkship and gathering information about the dynamic of the clerkship group. A clerkship director who is open and respectful of students is far more likely to be approached with information from students that may not be obvious from the faculty or resident evaluations of a student. Students need to know that they are free to bring concerns of any type to their clerkship director and that those concerns will be accepted, respected, and appropriately addressed.

Part of the clerkship director’s responsibility is to follow up on all less-than-favorable evaluations, whether they are given formally or informally. Optimally, this should be accomplished using formative feedback midway through the rotation, rather than right before the end because this allows learners sufficient time to take corrective action or redirect their behavior before any summative feedback [7].

The Difficult Student

Having a well-thought-out and -defined plan for how students are assessed is especially critical when the clerkship director is presented with a difficult student. These situations can consume a large amount of a clerkship director's time and can be draining, often diverting resources from the rest of the student group [6]. There is no doubt that Melanie is a difficult student and poses a problem for the surgery clerkship director. However, I would argue that Melanie's unprofessional and disrespectful behaviors toward her peers, regardless of setting, should not be framed by labeling her a "gunner"—using slang terms can imply a tacit acceptance of this dysfunctional behavior—but rather should be viewed as a “noncognitive difficulty,” an educational concern that deserves attention [8].

These are perhaps the most challenging of the difficulties students may demonstrate. Pure cognitive difficulties, such as inadequate clinical reasoning, lack of organization, lack of clinical efficiency, and poor knowledge base can often be easier for the clerkship director to address because the supporting data and paths of intervention and re-assessment are clearer.

In Melanie's case, the clerkship director should begin by gathering more information about the situation, discussing the concerns with the students and residents who raised them to make clear they are being heard and probe the degree of the problem. As time-consuming as this may be, it is important to gather all firsthand information relevant to the situation prior to addressing Melanie directly, so the clerkship director understands all aspects of the issue and is prepared to address them with her [8].

Applying the “SOAP” framework to learning situations, as suggested by Langlois and Thach, offers a nice approach to discussing such evaluations with their subject because it not only allows feedback to be given to the learner but also entails a plan for corrective action [9]. The framework recommends:

Subjective: Use your experience and opinion to gain an individualized impression of the student's difficulty.

Objective: Document specific examples of the problem.

Assessment: Diagnose the problem.

Plan: Develop and implement a plan to address the problem [9].

The development of a plan for a behavioral concern can be a bit more challenging than it is for academic shortcomings. The clerkship director may consider some well-known behavioral change strategies employed with patients, such as the transtheoretical model of change, to assess Melanie's understanding of her own behaviors [10]. Doing so ensures that the planned intervention is appropriate. The clerkship director is unlikely to change Melanie's attitudes and beliefs, or even what ultimately motivates her, so he can and should focus on Melanie's behaviors [8]. Taking behavioral change theories into consideration also acknowledges that behavior change is difficult and does not occur overnight but takes practice and time. When communicated in such language, this should allow the learner to feel safer in

accepting and looking at the process not as a punishment but as mentorship and an opportunity to grow as a physician.

The most challenging situation would be one in which Melanie's reaction reveals she has little to no insight into the way she is perceived by her fellow learners. In this case, the intervention must start by opening her eyes to her behaviors and their repercussions, making clear that this behavior, if unchanged, will negatively affect evaluations. For example, the clerkship director may have Melanie try to "walk through" the possible consequences of her actions [8]. In these instances, it is critically important to document the advisement given to Melanie and alert the appropriate education faculty to the situation so they can monitor Melanie's behaviors on subsequent clerkship rotations.

Strategies for Reducing Noncognitive Difficulties

360-degree evaluation. 360-degree evaluation tools, long used in the business world, involve comparing self-evaluations to those of people above, people below, and peers of the evaluatee. A version for medical learners was developed by a group of radiation oncology program directors [11]. It has been used increasingly in medicine over the past decade but is not necessarily widespread because it is labor-intensive and difficult to carry out in a timely fashion [12]. It is underutilized in undergraduate medical education most likely because of the relatively short time students spend in any one clinical learning environment.

If formal 360-degree evaluation—including both peer and self-evaluation—was the standard at the medical school or on the clerkships, the groundwork would already be in place for a more productive, open, and honest discussion with Melanie and would probably increase her acceptance of such feedback. If the system has made it clear from the very first day of medical school that learners will continually be assessed by their peers and that those assessments will matter to those who evaluate them formally, perhaps many of the competitive and self-promoting behaviors that arise in the clinical years could be prevented. Peer and self-evaluation are infrequently performed in most educational settings, and they would add much.

Peer evaluations seem to be less objective for colleagues with close personal ties, and may create a strong reaction when the student performing the evaluation is directly affected by a peer student's behavior [13]. But they tend to reflect extenuating circumstances, such as the impact of a resident's competency level on the student's growth and development, better than faculty evaluations [13, 14]. Self-evaluations often conflict with the evaluations of teachers and other team members; they are best used in a formative capacity to allow the students to compare their own assessments of their performance to the summative assessments they receive. This helps them develop the skill of self-evaluation to inform their own lifelong learning habits [13].

Curricular and cultural changes. Clerkship directors must assess the climate of professionalism in all of the clerkship environments and work with their faculty to

ensure it is conducive to students' internalizing desirable behaviors [15]. Cooperation with department chairs and residency program directors, who have the power to take punitive action when necessary [16], will send a consistent message that bad behavior by faculty will not be tolerated anywhere.

Clerkship directors should include professionalism in their formal learning objectives, communicate them to students at the start of the rotation, specify how professionalism will be defined and assessed, and make clear the ramifications of not meeting the objectives [15]. And, when it comes time to hand out grades, educators must hold firm to their standards. That way, students will understand that clinical knowledge and professionalism are being given equal weight.

Admissions. There is no national consensus about the qualities that make successful physicians. However, most organizations and academic medical schools agree on the importance of themes such as “compassion, coping capabilities, decision making, interprofessional relations, realistic self-appraisal, sensitivity in interpersonal relations, and staying power—physical and motivational” [17]. The wider adoption among American medical schools of the Multiple Mini Interview (MMI) process—in which students are rated on responses to hypothetical situations by a variety of interviewers, rather than on self-descriptions by one or two interviewers—indicates that more and more medical schools are prioritizing noncognitive factors when deciding which students to admit [18, 19]. The MMI has been shown to offer more information about the noncognitive qualities valued in students who will ultimately become physicians, and such techniques may be our most vital tool to help combat some of the less favorable behavioral tendencies and enroll more empathetic, humanistic, and kinder students in medical school from the outset [20]. In theory, this should produce a population of students who interact more respectfully with one another, if those values are properly reinforced in the curriculum.

Conclusion

One of the greatest challenges for clerkship directors is addressing the student who exhibits unfavorable behaviors toward anyone, including his or her peers. It is critical to take a thorough approach in investigating and addressing the student's behaviors directly and provide them the feedback as early in the clerkship as possible. Behavioral change theories such as those used to counsel patients may prove useful. Documenting advice and feeding information forward to academic administration allows clerkship directors to fulfill their responsibilities to the educational mission of their institution.

Working together with all levels of health care professionals has become the standard of care for the health care system. Being open to how we are perceived by others is extremely important to our professional development. There is skill in developing openness to feedback of all kinds, and not clinging too tightly to only the very good feedback, but accepting feedback in all its forms. This is something that all physicians should continue to practice and that students must learn early in their medical education.

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THE CODE SAYS

The AMA *Code of Medical Ethics*' Opinion on Sexual Harassment of Medical Students and Residents

Opinion 3.08 - Sexual Harassment and Exploitation between Medical Supervisors and Trainees

Sexual harassment may be defined as sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when (1) such conduct interferes with an individual's work or academic performance or creates an intimidating, hostile, or offensive work or academic environment or (2) accepting or rejecting such conduct affects or may be perceived to affect employment decisions or academic evaluations concerning the individual. Sexual harassment is unethical.

Sexual relationships between medical supervisors and their medical trainees raise concerns because of inherent inequalities in the status and power that medical supervisors wield in relation to medical trainees and may adversely affect patient care. Sexual relationships between a medical trainee and a supervisor even when consensual are not acceptable regardless of the degree of supervision in any given situation. The supervisory role should be eliminated if the parties involved wish to pursue their relationship.

Issued March 1992 based on the report "[Sexual Harassment and Exploitation Between Medical Supervisors and Trainees](#)," adopted June 1989; updated June 1994.

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MEDICAL EDUCATION

Role Play in Medical Education to Address Student Mistreatment

Alison M. Heru, MD

Medical student mistreatment is a significant problem. After graduation, medical students report their perceptions of prior mistreatment on the Association of American Medical Colleges Medical School Graduation Questionnaire (GQ). In 2013 the percentage of students who reported having been “publicly embarrassed” was 47.2 percent, and 23.3 percent reported being “publicly humiliated” [1].

Both medical schools and hospital systems are mandated to address mistreatment effectively. A Liaison Committee on Medical Education accreditation standard mandates that “a medical education program must define and publicize the standards of conduct for the faculty-student relationship and develop written policies for addressing violations of those standards” [2], and the Joint Commission’s leadership standards specify that organizations must “provide skills-based training and coaching for all leaders and managers in relationship-building and collaborative practice, including skills for giving feedback on unprofessional behavior, and conflict resolution” [3].

However, there is a lack of evidence of best practice for prevention and management of mistreatment and inappropriate behavior. Current dedicated attempts to make changes in physician practice have failed. A 12-year study at the David Geffen School of Medicine at UCLA—which included informal and formal mechanisms of reporting and resolving incidents of mistreatment; education for students, residents, and faculty; and open discussion of the topic at all levels—failed to decrease the GQ reports of mistreatment [4]. New ways of thinking about, identifying, and responding to mistreatment are urgently needed.

Formal CME activities have little effect on physician behavior [5]. In contrast, interactive CME sessions that provide an opportunity to practice skills are successful at producing change in professional practice [4]. Interactive, experiential learning has been gradually seeping into medical education at both the student and faculty levels. This article promotes the use of experiential learning, specifically role play, to address student mistreatment in medical education and in hospital settings. The goal of role play is to develop scenarios and scripts that teach faculty, residents, and students how to recognize, address, and prevent mistreatment.

What Is Role Play?

Role play is one type of simulation that focuses attention on the interactions between people.

The idea of role-play, in its simplest form, is...asking someone to imagine that they are either themselves or another person in a particular situation. They are then asked to behave exactly as they feel that person would. As a result of doing this they, or the rest of the class, or both, will learn something about the person and/or situation. In essence, each player acts as part of the social environment of the others and provides a framework in which they can test out their repertoire of behaviors or study the interacting behavior of the group [6].

Role play underscores the importance of the social context of learning and of the medical environment.

Role Play in Medical Education

Communication-skills training is common in medical education. In the Department of Medicine at Johns Hopkins University School of Medicine, Shocket and colleagues developed an improvisational elective to enhance medical student communication skills such as mindfulness, active listening, comprehension, acceptance, responding thoughtfully, and articulating ideas clearly [7]. Through improvisation, the students were able to reflect on and improve their communication styles. Eighty-one (81) percent of students surveyed rated their enjoyment as “tremendous.” The desire to experience something new and different from the standard medical curriculum was motivation for many students (67 percent). Most students (85 percent) thought that the concepts addressed were either “very much” or “tremendously” relevant to the care of patients. Psychiatric residents also benefit from role play, which helps them gain an appreciation of their peers’ perspectives and how they affect patient care [8].

Experiential learning is especially useful to understand how emotions affect behavior or cognition. In these situations, physicians can learn specific skills and techniques to ensure that their behavior is appropriate. For example, communicating bad news is frequently taught experientially. Role play can be done in person, in a virtual setting, or on the telephone. Virtual and phone role play were found to be better at teaching medical students how to communicate bad news than in-person role play because they reduced some of the discomfort involved [9].

Role Play and Student Mistreatment

Student mistreatment is tackled at Vanderbilt University School of Medicine with skills-training programs for everyone from students to deans. In their pediatrics program, the resident retreat uses role play to teach strategies to manage “difficult communications in situations that often trigger unprofessional behaviors with attending physicians, other residents, nurse colleagues, and patients/families” [10]. Their four-hour academic leadership program for new chairs, division chiefs, and center directors also uses role play to teach skill development [10].

Student mistreatment was tackled at the Alpert School of Medicine at Brown University with the use of role play to develop videotapes for schoolwide education. The residents who participated in the creation of the videotapes greatly benefited from the exercise [11]. One resident who played the part of a medical student subjected to mistreatment spontaneously reported experiencing self-doubt, self-blaming, and reluctance to report an incident. He stated that he would never have reached that insight by reading and that the experiential nature of the exercise had been pivotal in his understanding of what it feels like to be mistreated. Another resident who played an aggressor said that, as a result of the role play, she felt better able to handle complaints of mistreatment. All residents agreed that they were now more aware of mistreatment and the personal costs to the recipient.

Guidelines for Role Play

Medical schools can use role play to develop scripted answers to common scenarios. These “scripts” can provide guidelines for program directors and medical student advisors to respond to typical reports of mistreatment.

Students’ prior experiences with role play influenced their willingness to participate. In one study, despite 22.2 percent of students reporting prior unhelpful experiences, most (96.5 percent) found that the role play was helpful. Role play that evoked strong negative emotional responses and situations that lacked realism were noted as “unhelpful” [12]. For students who are unaccustomed to working experientially, it is important to introduce role play gradually, discussing the rationale behind it and beginning with low-key exercises. Allowing adequate preparation time for role play is well worth the investment.

Guidelines for role play with medical students include the following: an emphasis on the social and interpersonal interactions as crucial for learning; adequate discussion of the specific goals for the exercise, such as improved communication with patients; assignment of roles in a way that matches the student’s experience, providing a sense of comfort in their interactions; and structured feedback [13]. The following table identifies steps for a role play exercise that tackles student mistreatment.

Table 1. Role playing activity on “pimping”

Step	Activity
1	Discuss literature about pimping.
2	Read and discuss the case of Mary: “Mary, a fourth-year student rotating through pediatrics, was assigned to present a patient for morning report. She did not admit the patient herself and was told about this task 10 minutes before rounds began. She walked into the pediatrics library to find that the chairman was sitting in for rounds that day. Mary presented the case with the limited information provided by the resident’s history and physical. The chairman asked her questions that escalated from historical questions to more probing questions that she clearly did not know the answers to. He continued to push her until she began to cry. After rounds, the chairman apologized, stating that ‘in medicine we learn by feeling stupid sometimes. That’s the

	way it is” [14].
3	Discuss findings on mistreatment [14] and how they apply to the case.
4	Describe the purpose of role play: “The purpose of this role play is to try out this scenario and see what options there are for all sides.” Allow participants to ask questions, discuss and clarify possible roles, etc.
5	Assign the roles of chairman, Mary, and the witnesses. The leader should guide the students’ choice of roles with individual students’ personal experiences and the overall goal of the exercise in mind. Clarify that all participants are willing to play their roles.
6	Allow 5-10 minutes for each person to prepare for their role and to discuss with their partners how the role play will be enacted.
7	Role play.
8	Debrief and discuss.

Conclusion

The transmission of abuse most commonly occurs because the perpetrator was a victim of mistreatment as a medical student and knows no other way to relate to students—“this is how it was done in my day” is a common refrain. But the mistreatment of medical students is no longer acceptable in our profession. Preventing mistreatment from being transmitted to the next generation of physicians is one of the keys to solving student mistreatment in the medical profession. Experiential teaching, such as role play, is the most effective teaching method we have for laying bare the effects of mistreatment and helping teachers practice appropriate behavior.

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MEDICAL EDUCATION

The Socratic Method and Pimping: Optimizing the Use of Stress and Fear in Instruction

Robert C. Oh, MD, MPH, LTC, MC, USA, and Brian V. Reamy, MD

Many faculty and clinical instructors in medicine profess to use the “socratic method” as an approach to teaching. From the basic sciences to the clinical years, medical students can and should expect to be questioned “socratically.” The socratic method, in its pure form, births a new level of understanding in learners. In a clinical context, it uses questions to draw out a learner’s knowledge—bridging the gap between textbooks and clinical care [1]. What, then, does the term “pimping” refer to? Is it synonymous with socratic instruction? Those who have experienced an emotionally charged “pimping” session in which a professor peppered the group with difficult questions may have been scarred by the event. But is there a legitimate role in medical education for the fear and stress pimping inspires?

The Socratic Method versus Pimping

Socratic instruction. When teachers ask questions using the socratic method, the “answer” and the “goal” of instruction should be known. Questions and follow-up questions lead the learner to solve the problem him- or herself—often applying baseline knowledge to a clinical scenario. Instruction then, should focus on diagnosing the learner’s knowledge level and teaching to it. The method is used most effectively one-on-one, where potential humiliation and embarrassment are minimized. The ultimate goal of socratic instruction is to help the learner develop new conceptual relationships or reaffirm a baseline level of knowledge, leaving the students more engaged in self-directed learning, which is rewarding to their instructors.

“Pimping.” Pimping is poorly defined in the medical literature, but can be loosely understood as a form of questioning of junior colleagues by a person in power that affirms the hierarchal order in medicine [2, 3]. Pimping starts with the lowest on the totem pole and moves up the chain—medical students, interns, residents, and then chief residents are all questioned.

On the surface, pimping appears similar to the socratic method, and the two terms are sometimes used interchangeably. However, there are clear differences in the means and goals of the two approaches. In its worst form, pimping uses the power of status to embarrass and humiliate the learner in a group environment [3]. At its foundation, the goal of pimping is evaluative. Who knows the answer? Who doesn’t? But answering questions becomes a competition among peers, and, to the student, learning may appear secondary to the social dynamic invoked through the

questioning. Prototypical pimping questions are conceptually different from those used in the socratic method. They are often difficult or impossible to answer and often focus on trivial matters, such as irrelevant eponyms or arcane historical points that may be interesting yet devoid of educational value [2]. See table 1 for the difference between the socratic method and pimping.

Table 1. The socratic method versus pimping

Technique	Socratic method	Pimping
Goals	<ul style="list-style-type: none"> • Connect new knowledge to existing knowledge • Teach 	<ul style="list-style-type: none"> • Evaluate students • Establish hierarchal order • Teach
Types of questions	Probing and leading: making connections Ex: Why do patients get hypotensive when pyelonephritis is treated with antibiotics?	Factual, pertaining to history, eponyms, lists Ex: What is the Jarisch-Herxheimer reaction?
Optimal setting	One-on-one	Small group

Better Pimping?

There are few opportunities in the medical school curriculum for one-on-one clinical instruction and socratic teaching because, while it may be ideal, it is often time-consuming. Second, the fact of the matter is that professors must evaluate the students in some fashion and cannot always teach solely for the sake of imparting knowledge. Third, there is research to suggest that some stress and anxiety can be beneficial in learning. There appears to be a certain level of tension and disequilibrium needed to stretch and challenge students to learn [4].

But, as noted by Allan Detsky, pimping can be kinder and gentler [5]. One way to mitigate fear is to provide praise, public or private, after a good presentation. Detsky encourages instructors to take the “high ground” of pimping, with the goal of teaching rather than reinforcing hierarchal order. A small-group setting with different levels of learners is arguably the optimal setting for appropriate pimping. Handled this way, pimping can engage students more than lectures and stress them enough to increase retention of key learning points. Done well, pimping can help check the knowledge of the learner in order to reinforce key learning points. Exposure of students’ knowledge gaps can focus and enhance their self-directed reading and learning [3].

Practically, medical school teaching can be best accomplished in small groups like those of an inpatient ward team, consult service, or clinic. This format allows interactive reflection and the setting of standards for the learners.

What Students Want

One study reported on student perceptions of effective small-group teaching and identified several characteristics of the best small groups [6]: the environment is perceived by the students as not threatening, promotes problem solving, encourages group interaction, and is led by an effective tutor who emphasizes clinical relevance while optimizing student participation and working to adhere to the group's goals. For example, the tutor will identify quiet students and give them a chance to add items to the discussion or will redirect the group to stay focused on a session's goal. Students like to be able to think aloud and ask questions while checking their understanding of the material. They found particular value in learning from one another and applying content to real clinical situations to develop their problem-solving skills. Students also preferred instructors who did not "lecture" in a small group and appeared relaxed, engaged, and excited to be present.

Overall, the students emphasized the value of a small-group teacher as a "metacognitive guide." This type of teacher is able, without giving answers, to help the students raise the questions an expert physician would ask when thinking through a case. An expert tutor is described as an active listener focusing on the needs and skills of each participant [7].

Can students be engaged with thought-provoking questions without the fear of humiliation or embarrassment in small-group settings? We believe it is possible. Here are some key points from both a teacher and student perspective.

Pointers for Teachers

1. *Diagnose the learners (and teach to that level).* Ask questions to assess their baseline knowledge level. But don't embarrass; ensure that your goal is to help and motivate them to learn.
2. *Avoid asking questions for questions' sake.* Do students really need to know what year the stethoscope was invented? Avoid trivia, historical facts, nonmeaningful eponyms, and impossible, guess-what-I'm-thinking questions.
3. *Tell students your goal in asking questions.* Tell students up front that you will ask questions not to harm, humiliate, or embarrass, but to teach.
4. *Emphasize important learning points.* Link topics discussed to a clinical context for patient care, perhaps one in which clinical pearls are given to help to solve complex clinical problems.
5. *Do not attempt to intentionally embarrass or humiliate the students.* We all make mistakes, and reflection on the teaching encounter helps you to determine if you've asked irrelevant questions or if your learning outcome was unintended embarrassment or humiliation. Use this to improve your approach and questioning for future teaching opportunities.

Pointers for Students

1. *Give professors the benefit of the doubt.* If attending physicians ask difficult questions and if a student feels humiliated, the effect was most likely unintentional.

2. *Don't be afraid to speak up.* Be courageous and give teachers some feedback, whether directly or through your school's feedback system, especially if humiliating behavior becomes a recurring theme.
3. *Use the answers you know to reinforce your learning.* When you do know the answers, even if you don't say so out loud, take that as positive reinforcement that you are on the right track in learning the key points.
4. *Use the questions you don't know to motivate you to read and learn.* If you didn't know the answers, then write them down and hit the books hard and learn it well. This becomes a great needs-assessment tool to help you to learn and focus your studies.

Conclusion

The socratic method and pimping, while similar, are distinct teaching strategies with some areas of overlap. Small-group instruction is arguably the best way to teach clinical medicine and questions, whether asked “socratically” or by “pimping,” will persist in medical student teaching. Fear and stress can be useful when they spur the student to pursue self-directed learning and minimize embarrassment or humiliation. Perhaps most importantly, students should remember that they learn for the sake of their future patients—that one day, a patient may depend on them to know the correct “answer.” This, ultimately, is the type of fear that should drive the teacher to teach and the student to learn.

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MEDICAL EDUCATION

An Abuse-Free Medical School Environment: An Ethical Imperative

Joyce M. Fried and Sebastian Uijtdehaage, PhD

Ethics, Impact, Enculturation

Allowing mistreatment, bullying, and harassment in the health care environment is unethical not only because of the impact—e.g., depression, burnout, and fear—on trainees but also because bullying of trainees may harm patients as well. Moreover, experiencing or witnessing frequent sarcastic or humiliating comments and unprofessional behavior does not create resilient residents and students but, instead, burnt out and cynical professionals [1] who may perpetuate an environment in which the abused trainee takes out his or her cynicism and frustration on junior colleagues.

Unhappy and cynical individuals do not make good physicians. A British study [2] found that residents who had been subjected to “persistent behavior that has undermined [their] professional confidence and self-esteem” were more likely to report poor clinical supervision and, importantly, more likely to report having made serious medical errors in the previous month. Though understanding that relationship requires future research, abuse of trainees may be a patient safety issue.

Many studies in the United States and throughout the world have described the high incidence of mistreatment in medical schools [3]. It is widely agreed that mistreatment is enculturated in medicine; enculturation perpetuates it. Unfortunately, culture change moves at a glacial speed. Thus it is difficult to determine the effects of different interventions, to identify which are successful, and to link metrics to these efforts. The process can be disheartening. Nonetheless, there are policies and mechanisms that institutions can put in place that will lay the groundwork for changing the culture by making abusive behaviors unacceptable and eventually rare.

Laying a Foundation for an Abuse-Free Environment

Two complementary approaches toward abuse-free schools have been proposed [4]: institutionwide abuse prevention policies and interventions that target specific perpetrators of abuse. Policies give institutions grounds for action when individuals violate them. Institutions must articulate expectations, rules, and penalties that make it clear that retaliation for reporting is as bad as or worse than the original mistreatment.

Our institution, the David Geffen School of Medicine at UCLA, formed the Gender and Power Abuse Committee in 1995 to determine what was needed to address mistreatment of medical students, residents, and junior faculty. The goal was to establish a diverse, well-trained cadre who could provide informal assistance to

victims of gender and power abuse. Committee members represented a variety of interests, but their common purpose was eradicating mistreatment and bullying. Prior to the committee's existence, no one had been designated or trained to counsel and guide victims of mistreatment.

The committee's monthly sessions were designed to educate committee members on the nature of mistreatment, its effects, the literature on the topic, resources available for faculty, staff, and trainees to report it, and ways to respond. Topics included mediation, negotiation, sexual harassment training, active listening, violence de-escalation, rape counseling, and suicide prevention. Members became acquainted with UCLA resources such as the Staff and Faculty Counseling Center, the Center for Women and Men, the Mental Health Program for Physicians in Training, Student Wellness Center, and Counseling and Psychological Services and the types of problems these offices were seeing.

One of the committee's first projects was crafting the "Statement on an Abuse-Free Academic Community" to set forth the ideals of the school, identify specific unacceptable behaviors, and take a strong stance on retaliation and retribution. Adoption of this statement was followed by the creation of a formal policy for prevention of student mistreatment that was written by an expanded group of faculty, staff, residents, and students and approved by the faculty executive committee and the dean's office.

Next, the committee identified the need for a confidential, independent, neutral, and informal ombuds office, a place where health sciences students, faculty, staff, and administrators could go for informal assistance in resolving conflicts, disputes, or complaints. Although the campus has had a successful ombuds program for the last 50 years, it was little used by the health sciences community because of its remote location and the perception that its professionals could not grasp the particular culture and environment of the medical community.

The biggest obstacle to establishing an office dedicated to our needs was securing salary and office space in the health sciences complex. The first person to hold the office was an intern who needed practice hours and therefore volunteered her services under the strict supervision of the campus's head ombudsman. An unused darkroom was appropriated and renovated into office space.

From the day the health sciences ombuds office opened its doors, it has been highly utilized. Due to the privacy and confidentiality accorded to this function, we don't know how many cases it has resolved and the litigation it has avoided; we estimate that the number is significant.

Education and Awareness

Awareness on the part of the entire health sciences community of the policies and procedures, the mechanisms that will be used to investigate allegations, the consequences these behaviors will engender, and the resources in place for reporting

is essential to facilitating culture change. The Liaison Committee on Medical Education requires that students be made aware of the existence of these policies and the mechanisms for reporting mistreatment [5]. The AAMC Graduation Questionnaire includes questions [6] that monitor student awareness to ensure adherence to these requirements.

We have promulgated this information in several ways. Bookmarks that include the “Statement on an Abuse-Free Academic Community” on one side and contact information for the Gender and Power Abuse Committee members on the other were distributed to students, residents, faculty, and staff. Over the years, opportunities to spread the word have been embraced and a robust educational program. The interactive Draw the Line project created by the Organization of Student Representatives of the Association of American Medical Colleges was displayed and publicized and served as a springboard for discussion. We created a mandatory workshop for medical students beginning in their third year designed to define mistreatment, give them tools to counteract it, teach them about reporting mechanisms, and remind them of their rights and our expectations. Likewise, we offered sessions for onboarding residents, new and junior faculty, matriculating students, clerkship chairs, site directors, and department chairs. Grand rounds presentations have been given in the departments of surgery and obstetrics and gynecology (two specialties with traditionally high abuse rate reports [2]) and are available upon request to other units.

Monitoring

Monitoring the occurrence of mistreatment and tracking trends are critical components of culture change. We have been tracking student mistreatment since 1997, when we first administered a student well-being survey at the end of the third year while the experiences of our students in the required clerkships are still fresh in their minds. We also closely monitor our data in the Association of American Medical Colleges Graduation Questionnaire, which is administered toward the end of the fourth year. For the past nine years we have included questions on mistreatment in an annual survey administered to housestaff and have tracked trends from the results of that instrument.

As reported in our study published in *Academic Medicine* in 2012 [3], our efforts have not resulted in substantive decrease in reported mistreatment. We believe that this may be because we did not have the means to correct bad behavior soon after it occurred. Based on successes in improvement data at the University of California, San Francisco School of Medicine (Maxine Papadakis, personal communication), we recently added mistreatment-related questions to the mandatory but anonymous evaluations of clerkships by medical students. Specifically, we ask students to indicate whether or not each attending or resident physician with whom they worked treated them with respect and was observed treating others with respect. This helps us target specific perpetrators of mistreatment sooner. Since we added these questions to the evaluation we have noticed that more students than ever before are coming forward to report mistreatment to Gender and Power Abuse Committee

members. The senior associate dean for graduate medical education addresses reported unprofessional behavior by residents, and the vice dean for faculty, unprofessional behavior by faculty. A database tracks offenders; severity of consequences increases for repeat offenders. We believe more timely consequences and interventions may be a key to culture change.

Lessons Learned, Future Plans

While eradicating mistreatment from its entrenchment in the medical culture is rife with frustration and disappointment and may seem like a Sisyphean task, institutions cannot afford to give up. One of our biggest challenges and barriers over the long run has been our inability to discipline perpetrators because we did not know who they were. Our students and residents were not afraid to report that they had experienced mistreatment in our anonymous surveys but were reluctant to identify perpetrators. By adding the “respect” questions to our evaluations and by providing the students and residents with a safe reporting system, we have now positioned ourselves to be able to mete out consequences.

The entire leadership team—including clerkship chairs, program directors, department chairs, division chiefs, and deans—must be involved in the process. Data must be fed back to groups and individuals so that they can take ownership of the problems in their specific areas. We also believe it is important to establish institutionwide preventive measures in addition to targeting specific sources of mistreatment shortly after it occurs.

Furthermore, in addition to punitive or corrective actions, outstanding behavior needs to be spotlighted and rewarded. We recently asked our student leaders to present us with a proposal to provide awards and recognition for residents who model exemplary teaching and respectful interactions. Resources will be provided to implement their plan.

Finally, we must continue to be mindful that, as the literature bears out, this is a national (and international) problem. We know that mistreatment is a learned behavior. When medical students become residents and residents become faculty members at other institutions around the country they take with them the behaviors that were modeled earlier in their training. This makes it all the more imperative that we work together as a professional community to change the culture by sharing successes, failures, and best practices so that we can all build on these as a community rather than institution by institution. The well-being of our students, residents, and physician workforce, and, by extension, that of our patients, is at stake.

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MEDICAL EDUCATION

Feminist Learning Strategies in Health Professions Education

Nancy J. Michela, DA, MS, RN

Traditional education serves as a “reproduction of existing societal power relationships and structures, through both its methods and content” [1]. Power struggles in the classroom between students and faculty control play a role in reducing student motivation and overall learning [2]. Paolo Freire’s classic text, *Pedagogy of the Oppressed*, encourages the liberation of oppressed groups through empowering, mutual models of education [3]. This approach is one of the major influences in feminist pedagogy, which seeks to empower women and thus, historically, nurses [4].

Empowerment is critical to the nurse’s ability to create change in health care and society at large [2]. Feminist pedagogy can help bring this about. Although limited, a study by nurse researchers found that use of feminist pedagogical techniques was likely to increase student empowerment in the classroom as well as in personal and workplace environments [4]. Welch supports the inclusion of feminist pedagogy in nursing education because it makes classrooms more democratic and helps students deal with patriarchal physicians, and I think this is applicable in all health professions education [5]. Furthermore, implementing these feminist learning strategies will get health professions students ready for the collaborative, interprofessional “real world.”

Feminist pedagogy that is grounded in ideals of gender equity, societal value based upon individual capacity, and caring promotes “development of an atmosphere of mutual respect, trust, and community in the classroom; shared leadership; cooperative structures; integration of cognitive and affective learning; and action” [6]. Feminist pedagogies can “change the classroom into a more egalitarian structure allowing students and teachers to share information and points of view in an open setting” [7]. Nursing faculty I surveyed identified many feminist learning strategies being used in the nursing classroom, including: case studies/scenarios, small-group sessions, journaling, cooperative learning, collaborative group process, consensus building, shared governance, and social activism [8].

Case studies and scenarios have long been a means of examining issues in nursing. Such strategies give students opportunities for active involvement in the learning process, thus promoting increased cognitive and affective thinking skills [9]. Case studies are especially effective in teaching broad concepts, such as pain or nursing care of a specific disease. Herman [10] found that the case study can be divided into

segments, and, throughout a sequence of events, students can recall cases to reinforce their decision-making processes or application of the content.

Journaling about class content or clinical events has been integral to cultivating a student's voice and establishing a personalized and constructed knowing. Students employ writing opportunities to "detail dimensions of *doing* nursing and of *being* a nurse" [11]. Kok and Chabell found that journal writing in clinical nursing education promoted critical thinking and problem solving skills through reflection. Well-developed journal guidelines resulted in positive student perceptions of this strategy [12].

Cooperative learning eliminates hierarchy in the classroom or clinical setting; Beck found this creates a sense of community for students and educators [7]. Student pairs can gain insight from one another and learn to work together as a team. This strategy, called "think pair share" by Herman, can be useful in creating personal connections to classmates and the material in large classes [13].

Small-group sessions can be used in larger classes to increase discussion and engagement. Ruffing-Rahal observed that these sessions "strengthened consensus regarding core professional values and identities" [11]. Students found the strategy facilitated their ability to communicate within groups and develop a sense of accountability and responsibility to the group's members [14].

Collaborative group process and shared governance let the students learn independence from their instructors and mutuality with their classmates. Students share responsibility for classroom discussions and sequencing of content [15]. Collaboration is a core element of interprofessional core competencies, such as "deliberatively working together" [16].

Social activism forges the connection between the classroom and the larger society to motivate students to create change. Any opportunity to promote nursing action grounded by everyday reality is the goal. Students working a farmers' market or health fair are examples of this strategy used outside the traditional clinical setting [8]. In one study [17], second- and third-year nursing students developed and implemented a health promotion program based upon a community needs assessment. Outcome data showed students perceived they had increased skills in health promotion, clinical assessment, civic engagement, and research.

Faculty I surveyed reported that most of these strategies met with student satisfaction expressed in qualitative anecdotal appraisals and course evaluations [8].

Nursing educators must continue to develop and implement curricula that help students learn approaches to developing good communication and critical thinking and to fostering appropriate professional behavior toward peers, colleagues, and patients [18]. Feminist learning strategies can fill that need for nursing and other health care professions curricula.

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Measuring Mistreatment: Honing Questions about Abuse on the Association of American Medical Colleges Graduation Questionnaire

Brian Mavis, PhD

Is it possible that medical school is a place where medical students are actually abused? This was the question posed in 1982 by Henry Silver, as he observed a new matriculating class of “eager, alert, enthusiastic and excited medical students” and considered that, for some, medical school would result in a gradual personal transformation shaped by fear, sadness, dejection, and frustration [1]. A subsequent survey revealed evidence to support the idea of medical student abuse, for the most part limited to the clinical years of training, but affecting some practitioners for years thereafter [2]. A particularly telling finding of the study was that most deans of students surveyed denied that student abuse existed.

For several years after these pieces were published, there was relatively little research on medical student abuse. Only recently have medical educators come to understand the prevalence, complexity, and significance of this problem and taken action. The Association of American Medical College (AAMC) advisory committee for medical student surveys, of which I am a member, has been exploring the potential of its annual Graduation Questionnaire (GQ) to better characterize the depth and breadth of medical student abuse. This has resulted in a number of changes to the questionnaire administered annually to graduating medical students.

The AAMC GQ has been administered to graduating medical students since 1978, with the goal of exploring their perceptions of medical education quality, specific educational experiences, medical school resources and infrastructure, debt load, and career plans [3]. It remains one of the richest longitudinal datasets for understanding medical education from a student’s perspective. When questions related to mistreatment were added in 1991, the GQ became the only comprehensive source for information about the mistreatment of medical students.

Recent trends in the GQ mistreatment data suggests that reported mistreatment has been consistent over time. Since 2000, 13 to 20 percent of graduating medical students report that they have been mistreated, with clinical settings the mostly likely place for these incidents [4]. When medical schools are compared, the proportion of graduates reporting mistreatment varies widely from approximately 5 to 40 percent, but averaging 17 percent [5].

From the beginning, the inclusion of mistreatment questions as part of the GQ has presented two major challenges: defining mistreatment and clarifying the role of

subjective experience in determining whether or not mistreatment has occurred. Efforts to respond to these two challenges have involved three interrelated strategies.

The first was generating a list of specific situations that could be considered mistreatment. In 1991, the GQ core questions about mistreatment focused on the extent to which gender, race and ethnicity, and sexual orientation resulted in denial of educational opportunities, lower evaluations or grades, or offensive names and remarks. These were supplemented with questions related to instances of public humiliation, threatened or actual physical harm, requests to run personal errands, sexual harassment, and others taking credit for a student's work. Since then there have been many changes in the content and wording of the mistreatment questions, with new situations and personal characteristics being added to or removed from the list. The current 15 questions contain many of the core questions about general mistreatment as well as mistreatment associated with gender, race and ethnicity, sexual orientation, and sexual advances.

In 2000, the next strategy to help respondents report on mistreatment was the addition of a question asking whether respondents had been personally mistreated during medical school. The significance of this question was twofold. First, it provided a screening question; only when respondents answered affirmatively were they asked follow-up questions about the nature of their mistreatment. Second, it provided an opportunity for respondents to report on their subjective experience of being mistreated.

In 2001, a third clarifying strategy was to add a definition of mistreatment to the questionnaire to guide respondents. The 2011 update of the definition read,

Mistreatment, either intentional or unintentional, occurs when behavior shows disrespect for the dignity of others and unreasonably interferes with the learning process. Examples of mistreatment include sexual harassment; discrimination or harassment based on race, religion, ethnicity, gender, or sexual orientation; humiliation, psychological or physical punishment and the use of grading and other forms of assessment in a punitive manner [3].

Collectively, the three strategies have worked reasonably well, but they have also highlighted the complicated nature of measuring mistreatment. A majority of the situations represented by the 15 core questions are specific occurrences, such as physical punishment, being asked to exchange sexual favors for grades, and denial of opportunities or offensive remarks based on personal characteristics. There is little debate that these experiences represent mistreatment. Less clear and more troubling has been the data related to the question "have you been publicly belittled or humiliated?" Prior to 2000, 40 to 50 percent of medical students answered this question affirmatively [5]. Since the screening question "Have you been personally mistreated during medical school?" was added in 2000, 13 percent to 20 percent

have reported that they were mistreated; most of that group also reported public humiliation or belittlement [4].

This change in format suggests that not everyone who reports being belittled or humiliated believes that he or she was mistreated and highlights the subjective experience of respondents in these situations. For example, two students being pressed by questions from an attending physician can come to different conclusions about that experience based on their personalities, situational factors such as mood and fatigue, and beliefs about the physician’s intent and what constitutes mistreatment. We attempted to remedy this variance by changing the wording of the question to “Have you been publicly humiliated?” The result was that, in 2012, 34 percent of respondents nationally indicated that they had been publicly humiliated; this decreased to 23 percent for the 2013 survey [6, 7].

At the same time, the screening question “Have you been personally mistreated during medical school?” was removed in 2012, and all GQ respondents were presented with the modified list of specific questions. With all respondents reporting on the same specific occurrences, the results (see tables 1 and 2) will provide a better estimate of the incidence, types, and sources of mistreatment now and serve as a benchmark for the future as institutions make efforts to address these concerns. With solid data, the hope is that we can work to improve the educational experience for medical students. The GQ is a rich data source for understanding the depth and breadth of mistreatment, but the data are limited in that they reflect only medical students’ experiences, while perspectives from other stakeholders are less well articulated.

Table 1. Most frequent occurrences of mistreatment reported on the 2013 AAMC GQ, in descending order of frequency [7]

Occurrence	Percentage of students who reported experiencing it
Public humiliation	23
Sexist remarks	14
Requirement to perform personal services	9
Racially or ethnically offensive remarks	7
Denial of opportunities for training or rewards solely based on gender	6
Lower evaluations or grades solely because of gender	6
Unwanted sexual advances	5

Table 2. Data from the 2013 AAMC QG on unreported incidents of mistreatment [7]

Percentage of students who answered yes to one or more question about experiencing mistreatment	42
Percentage of students who experienced but did not report mistreatment at their medical schools	23
Of those who experienced but did not report mistreatment, the percentage whose reason for not reporting was that it did not seem sufficiently important	57 of the above group

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POLICY FORUM

Anonymous Surveys to Address Mistreatment in Medical Education

Georgette A. Dent, MD

Mistreatment remains a challenging problem for US medical schools [1]. The toxic effects of mistreatment on medical students are well documented—demoralization, a loss of empathy, impact on specialty choice, and stress, including symptoms of posttraumatic stress [2-5]. More than 10 years after the Liaison Committee for Medical Education (LCME) added a standard on mistreatment to medical school accreditation standards, responses to the Association of American Medical Colleges Graduation Questionnaire (GQ) continue to show that significant numbers of medical students experience some type of mistreatment. In the 2013 GQ, 42 percent of students reported experiencing mistreatment—most commonly public embarrassment, public humiliation, and being subjected to sexist remarks [6]—and 23 percent reported witnessing other students being mistreated [6]. Review of GQ data reveals that mistreatment is largely a problem in the clinical environment and that the most common perpetrators are clerkship faculty in clinical settings and members of the house staff, followed by nurses [6].

During the past few years I have had the opportunity to attend professional meetings and visit medical schools to discuss the issue of medical student mistreatment. I have also worked with others at my own medical school to develop strategies to reduce, if not eliminate, this problem. In my experience, anonymous student surveys are crucial to efforts to address mistreatment; without them, progress cannot be made.

Having good data—both qualitative and quantitative—is essential to rooting out mistreatment, because without it the problem cannot be understood. Compelling stories of students who were humiliated, subjected to sexual harassment, or exposed to racist or homophobic slurs can be extremely useful in convincing faculty and staff that a problem with mistreatment exists and that they must change their behavior.

To obtain useful data on mistreatment from students, schools must have the ability to use anonymous surveys. Studies have shown that anonymous surveys in general are more effective in acquiring sensitive information than those that are not [7]. Studies on medical student evaluations of faculty in particular have shown that the use of nonanonymous instruments leads to positive information being reported more positively and negative information being reported less negatively [8, 9]—in other words, inaccurate data.

Students do not accurately report mistreatment when their comments will not be anonymous because they fear retaliation. More than a quarter of respondents to the

2013 GQ identified fear of reprisal as one reason why they did not report incidents of mistreatment [6]. It is not realistic to expect that students will divulge qualitative data on the behaviors of house staff and faculty unless they are completely free from the fear of retaliation.

A good process for combating mistreatment prioritizes improving the learning environment over punishing offenders and minimizes the fear of reprisal. Anonymous information does not enable punitive actions because it prevents the verification of allegations and the preservation of “due process”-style rights to face one’s accuser [10], but it can work well when used to give clinical educators constructive feedback on ways to create a positive learning environment for students. It is not unusual for faculty, house staff, nurses, and other perpetrators of medical student mistreatment to be simply unaware of the way in which their behavior is being experienced by learners, so accounts of mistreatment can be important tools for improving their teaching. In the event that mistreatment is so severe that a punitive action is warranted and the student’s anonymity cannot be preserved, the school must make it clear to the alleged perpetrator that any attempt to retaliate against the student will be met with severe action.

The Liaison Committee on Medical Education standard MS-32 mandates that “A medical education program must define and publicize the standards of conduct for the faculty-student relationship and develop written policies for addressing violations of those standards” [11]. Schools that are effective in addressing mistreatment have policies that are simple to understand and implement, have a strong educational component, and include both provisions that insure freedom from retaliation and due process for the alleged perpetrators. Systems explicitly intended to discourage reprisal send a clear message to educators and students that mistreatment is not desired and will not be tolerated.

Conclusion

Some medical schools use surveys and faculty evaluations that can be de-anonymized to obtain information from students. There are compelling reasons for doing this. Having the ability to de-anonymize a survey makes those filling it out more accountable for their responses. Surveys on the teaching performance of faculty can have significant implications for a faculty member’s career and can be the basis for promotion, tenure, and bonuses. Surveys reporting the unprofessional behavior of faculty can be used for even higher-stakes decisions, such as termination of employment or possible legal action. Anonymous student surveys and evaluations are in some respects similar to anonymous “poison pill” letters, and their use in the faculty promotion process is frowned upon by some [12]. In addition, knowing how to give constructive feedback is an important skill for a professional, and having the ability to de-anonymize a survey allows educators to give individual students metafeedback on the quality of their evaluations.

While these are important points, I believe the advantages to administering anonymous student surveys far outweigh the disadvantages. The vulnerability of

students cannot be overstated, because of the power differential between them and faculty and house staff. Students are afraid that reporting mistreatment could negatively impact their grades, their ability to match in a residency program, and their ability to graduate. While anonymous surveys are also an important tool in assessing the effectiveness of faculty teaching and the quality of medical school educational programs, they are particularly important in combating mistreatment. Any movement toward using de-anonymized surveys will compromise the ability of schools to obtain valid data on student abuse and attendant efforts to reduce the problem of student mistreatment, which, many years after the landmark article by Kassebaum [13], continues to be a challenge for medical educators and students.

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MEDICINE AND SOCIETY

Moving Away from Hazing: The Example of Military Initial Entry Training

Gia A. DiRosa, PhD, and Gerald F. Goodwin, PhD

While veterans can attest to the hardships and horrors of combat, historical accounts suggest that some of the most harrowing experiences for Soldiers took place in basic training. [*Editors' note: The US military requests that capital letters be used in naming enlisted personnel, e.g., Soldiers, Airmen, Marines.*] There is a long history of sanctioned abuse of new recruits by their drill instructors during initial entry training (i.e., “boot camp”) for the armed forces. Severe mistreatment on the part of instructors is recorded as early as the beginning of the twentieth century at the United States Military Academy [1] and continued well into the modern era. Biographies of Vietnam veterans describe ritualized cruelty ranging from verbal insults and derogatory comments to physical injury such as being punched repeatedly in the stomach or forced to eat garbage [2-4]. These stories were not isolated incidents; at the time, they were considered an integral part of the training process. Drill instructors acted on a sense of duty to strip recruits of their old civilian lives, including their dignity, in order to prepare them for military careers.

Today, this behavior—in which an oftentimes-more-powerful individual or group uses that power to force less powerful people to accept risk, humiliation, or abuse as a form of punishment or rite of passage—is recognized as hazing [5]. It has been used to enforce a particular standard or code of conduct or to initiate new members of a group [5]. For the military, endurance of this maltreatment was viewed as an indicator that a new recruit was successfully tested and ready for the rigors of military life. However, the military has made a cultural shift with respect to hazing, now regarding it as cruel, unnecessary, and inconsistent with its core institutional values, and is accordingly strictly intolerant of these behaviors. The military continues to work towards eliminating hazing in basic training and continues to make great strides in this effort.

Medical education has also historically used hazing as a rite of passage for students and resident physicians [6, 7] but is now seeking to rid programs of such socially accepted abuse. In this effort, the medical community can look to military practices and experiences in erasing hazing from both the training environment and the overall culture.

The Purported “Benefits” of Hazing

Despite the cruel nature of hazing, it stems from more than simply sadistic motivations. Initially, harassment was implemented in military contexts because of its purported benefits to the larger organization. Specifically, hazing was seen to

serve three functions—socialization, cohesion-building, and weeding out those unfit or unwilling to serve. It was felt that socialization required that the existing principles and habits of new recruits be “broken down” and eliminated for the principles and norms of the group to be instilled in them. Lewin labeled this eradication of existing principles and habits *unfreezing* and identified it as a critical first step in his three-step model of change [8]. In this model, old values and attitudes are erased in the *unfreezing* phase, while new values and attitudes are learned in the *change* phase and crystallized in the *freezing* phase (see figure 1). The abuse suffered during basic training was seen as a way to break or “unfreeze” new recruits so that military ideals could be taught and cemented.

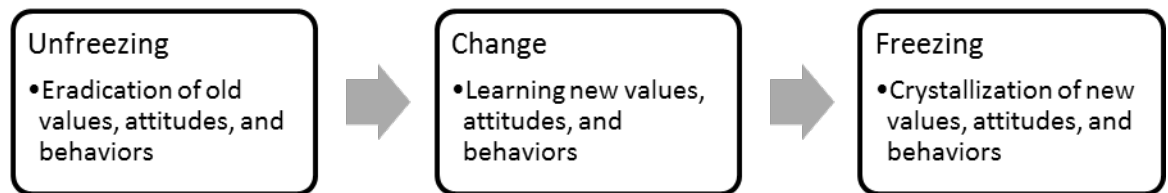


Figure 1. Lewin’s Model of Change (1947) [8]

Second, hazing was seen as a way to build camaraderie among new cohorts. Shared stressful experiences have been shown to foster cohesion among group members [9-12]. In basic training, that common stress was created in the form of hazing and harassment from drill instructors. This resulted in new recruits developing a strong commitment to their fellow trainees and the military itself—according to the theory of cognitive dissonance [13], new members would justify their unpleasant experiences by increasing their valuation of the group [14].

Third, hazing was viewed as an effective means of weeding out those who were either too weak for or not fully committed to a military career [15]. According to this argument for hazing, the willingness to endure abuse would effectively demonstrate a new Soldier’s intrinsic motivation to join the armed forces [14, 16-19]. Any trainee who could not or would not submit to the physical and mental abuse doled out during basic training was classified as weak or lacking the motivation and dedication to make sacrifices for his fellow Soldiers and branch of service. In either case, the recruit considered unfit for service would be weeded out through hazing.

The Military’s Transition

In the last few decades, it has become clear that the dangers of hazing far outweigh any purported benefits and that these same goals can be achieved without hazing. Since this realization, the military has made a concerted effort to eliminate sanctioned hazing in basic training and align its training methods with its values of dignity and respect through training, education, and regulation. Army regulations now cite hazing as being “fundamentally in opposition to [military] values” [20]. Drill instructors no longer have full autonomy in how they conduct training or discipline recruits, and methods of training that avoid hazing are stressed to prospective drill instructors in the drill instructor school. Derogatory terms, punitive

or excessive physical activities, and any abusive or violent physical contact are now expressly forbidden and punishable by the Uniform Code of Military Justice (UCMJ) [20]. As a result, the last 10-15 years have seen a significant reduction in incidents of hazing during basic training [21].

Despite the arguments in favor of hazing noted above, the eradication of hazing has not diminished the socialization, camaraderie, or commitment of new recruits. The military has since recognized that the physical, emotional, and mental hardships inherent in basic training are already significant. Recruits are isolated, far from home, flooded with new information, and required to achieve peak physical condition. The military has recognized that these challenges are more than sufficient for producing the outcomes that were previously associated with hazing without posing the considerable dangers of ritualized harassment. Even as early as the 1950s, when hazing during basic training was not regulated or even discouraged, the military recognized that a “knowledge of common interests, and a common identity serves as a unifying force” [22]. Today, the common interests and identity cultivated during basic training are built on a foundation of socialization, cohesion, and commitment without the cruelty of ritualized abuse from instructors.

This is not to say that basic training has become any easier or less rigorous since the eradication of hazing. Recruits are still subjected to a number of arduous tasks and conditions. However, these tasks directly relate to legitimate training objectives and give recruits a realistic preview of the challenges of a military career [14]. For example, recruits are required to run long distances while carrying heavy loads of equipment during basic training—a physical capability that is likely to be called upon in a combat environment. U.S. Army Training and Doctrine Command (TRADOC) regulation 350-6 specifically notes that “physical and mental hardships associated with operations or operational training” do not constitute hazing [23]. Hence, drill instructors are expected to enforce these activities, but only to prepare recruits for the tasks and objectives they will be faced with in the course of their military duties.

Lessons for the Medical Community

A medical career and the training required to prepare medical students parallel the conditions of a career in the armed forces. Like Soldiers, doctors are required to apply extensive amounts of procedural and declarative knowledge in a fast-paced, high-stakes environment. Due to these taxing requirements, it is not surprising that the medical community has also implicitly or explicitly used hazing as a means to weed out unfit interns and sufficiently prepare the remaining students for the rigors of a difficult career ahead. Junior residents are subjected to humiliation, belittlement, and verbal abuse from senior residents and attending doctors [6, 7, 24]. However, it is becoming clear that the hazing students receive when beginning their residency can be dangerous and unwarranted. A culture of mistreatment not only creates a hostile learning environment, but also causes breakdowns in trust and communication that can jeopardize patient safety [25].

In their efforts to change this culture, hospitals and residency programs can learn from the military's attempts to eliminate ritualized hazing while still conducting effective training. Like Soldiers in basic training, medical interns will experience extensive rigors during their residencies, including long hours, overwhelming amounts of information, and very high costs of failure. Not only do these circumstances suffice to prepare students for medical careers, but they also effectively socialize individuals and create camaraderie and commitment within cohorts.

Nevertheless, hazing has long been a part of the culture of clinical medical education and residency programs, much as it was a part of the military culture. Erasing hazing will therefore require a change in culture, which can be a difficult and prolonged process. It begins, however, with a commitment by those at the top of the organization. Similar to the military's regulations against hazing, internship programs should also have explicit policies that define mistreatment and delineate the consequences for such actions. But writing policy is not enough; leaders must implement policy with a strict zero-tolerance approach. Rather than attempting to weed out interns, organizations must shift their focus to disciplining or extracting instructors who do not comply with antihazing policies.

In addition to ridding training programs of a culture of hazing, environments like the military and medical community will also benefit from building a new culture of supportive learning and psychological safety. This culture is one in which instructors are viewed as mentors, not disciplinarians; mental toughness is demonstrated by consistently high performance, not endurance of harassment; and mistakes are viewed as opportunities for growth, not humiliation. Actions on the part of organizational leaders to demonstrate and implement these cultural paradigms not only reduce incidents of hazing but also create a productive learning environment. Through these efforts, the medical community can join the military in producing effective professionals without the added abuse and potential dangers of ritualized hazing.

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IMAGES OF HEALING AND LEARNING

The Hanging Medical Student: Sacrifice and Authority in Medical Education

Tripp Leavitt

In looking beyond medicine's traditional boundaries, there is potential to gain new perspectives and insight for the enhancement of our profession. In this article, the theme of bullying in medical school will be discussed through the lens of art. Analysis and discussion of art are most commonly used in medical education to hone skills of clinical observation and sensitivity to patients [1-7], even among more-seasoned practitioners [8]. Arts-related interventions have also been used to enhance teamwork and communication skills in both students [1, 9] and postgraduates [10]. Additionally, such activities have led to an improved tolerance for ambiguity [1, 10, 11] important in the clinical setting in which diagnoses may not present themselves immediately.

The integration of arts-related exercises beginning early in medical education contributes to an environment of learners and teachers in which medical student mistreatment can be curtailed at a foundational level. Art interventions, for example, emphasize positive communication among colleagues and discourage unhealthy dialogue that leads to bullying. Furthermore, because they center on topics outside the practice of health care, artistic discussions can foster equitable contribution from all participants, irrespective of professional role. In some sense this levels the playing field among health care workers, which helps counter the negative impact of hospital hierarchies [1]. Given the emerging roles that art and the humanities have come to play in medical education, it seems fitting to use art as a reference point in discussing themes of medical student mistreatment.

The bullying and mistreatment of medical students is a complex and contentious topic. There is a tendency to see bullying as a "necessary evil" and a rite of passage in medical education, valuable because it instills resilience and cements bonds between fellow doctors. Certainly there is a need to prepare medical students for the stress and responsibility that go hand-in-hand with the practice of medicine. However, is the "hazing" that may occur on the wards an ethical means of attaining this goal? There is no easy answer to this question, but it is imperative to consider that both present and future patient care is compromised in an environment that tolerates disrespectful behavior [12].



Figure 1. Tripp Leavitt, *Le Pendu*, 2010, lithograph and watercolor on paper, 11 x 15

The lithograph (figure 1), entitled *Le Pendu*, translated as *The Hanged Man*, is an interpretation of the pursuit of knowledge and enlightenment referred to in the tarot card of the same name, which served as its inspiration. *Le Pendu* can represent the transition that occurs through medical school: preclinical instruction provides the foundation of knowledge that is later developed and applied in the treatment of patients. Hands are a recurring theme in my work because I believe they symbolize so much of what it can mean to be human and because they have been historically associated with the art of healing. The living foliage represents the natural world from which we derive our knowledge of the basic sciences. Traditional perceptions of scale are made irrelevant as a laminin molecule appears comparable in size to a hand, emphasizing the fundamental links between microscopic and macroscopic realms of the natural world and the idea that we exist because of things too small to see or sometimes even comprehend.

Though depicted in its cross-shaped diagrammatic form, the laminin molecule refers to an aspect of medical education that is anything but straightforward. On a cellular level, laminin is a fundamental structural protein, serving the critical function of binding our cells together, akin to molecular glue. This rendering of the laminin molecule represents a link, in this case between scientific theory and its successful implementation in patient care. It is during these years that students take their crucial first steps from acquisition of medical knowledge to its patient-centered application. This linkage also contains the hidden, unwritten curriculum of the clerkship years. Between different students and hospitals it may be filled with inconsistency, and for some it may go so far as to become a “religious” experience; we may be deeply influenced by the dogma of our institutions, emblemized by the laminin cross. The quality of this link influences how a medical student practices as a licensed clinician. It is also during this transition that bullying can exert its more insidious effect, draining the empathy and quality of patient care in the years to come.

Looking at *Le Pendu* through the lens of the tarot card reveals a deeper narrative about the developing medical student. The Hanged Man is traditionally depicted as a figure suspended upside-down from a gallows, tied at one ankle, with his arms bound behind him, forming a triangle (figure 2). His free leg is crossed behind the one from which he hangs. The man’s face is not one of suffering; instead he exudes a sense of peace and contemplation.

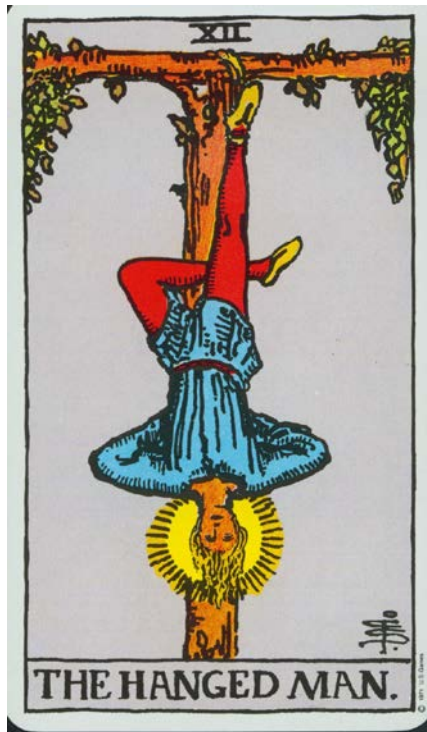


Figure 2. *The Hanged Man* tarot card

There are several parallels between the tarot figure of the Hanged Man and the student within the institution of medical education.

Central to *The Hanged Man* card are themes of contemplation and the attainment of knowledge and new perspectives through sacrifice. As his expression of peacefulness suggests, the Hanged Man is a willing victim, accepting that he must sacrifice in the name of a higher calling. In the twenty-first century, medical students invest significant time, energy, and money to eventually join the ranks of health care workers. It is a long road, and like the Hanged Man, one must exercise patience to achieve enlightenment.

The Hanged Man's fate is also intertwined with that of an authority figure. His legs cross in the shape of the number 4, implying his link to the fourth trump card, *The Emperor* (figure 3).

The Emperor is interpreted as a figure of authority, power, and discipline. His granite throne—sometimes understood as a kind of intellectual throne—emphasizes his fixed state, and he is the embodiment of law and rationality, knowledge, and consciousness. As the Hanged Man is connected to The Emperor, the fates of medical students, too, are connected to those of their mentors. Unlike students in many other graduate educational programs, medical students for the most part do not pave their own paths to discovery. Instead, we rely significantly on others to teach us. We must follow the guidance of our superiors, for they have the knowledge and experience that can transform us into effective clinicians. The aspect of apprenticeship in medical education has been one of medicine's greatest draws in my own choice of career. However, this apprenticeship also feeds into the rigid hierarchy that has become the accepted order in the health care setting.



Figure 3. *The Emperor* tarot card

The prevalence of demeaning behavior directed towards subordinates is varied, but the general consensus suggests that it is far from uncommon [13, 14]. Medical students, particularly in their third year, are common targets as they are at the bottom of this hierarchy. Burnout and clinical depression are two potential results of this behavior [15, 16], and mistreatment of members of the health care team seeps over into suboptimal patient care [12].

Medical students on clinical rotations are perhaps especially likely to empathize with The Hanged Man, for *The Hanged Man* card, when drawn together with *The Emperor* card, suggests that the best approach to conflict with a superior is complete passivity, echoing what may occur during clerkships. Leape et al. attributed significant underreporting of student mistreatment to concern for “being seen as trouble makers and fear of reprisal or vindictive retaliation,” including negative evaluations and implications for residency applications [12].

On its own, a reading of *The Emperor* card would suggest basing future decisions on a firm foundation, such as repeating learned actions rather than establishing new paradigms. Simply put, we teach the way we were taught. In the decades of practice after graduation, medical students may perhaps change from sympathizing with The Hanged Man to identifying with, or acting as, The Emperor. Repetition of the harsh training methods of the past is often considered to be a root cause of health care worker mistreatment patterns, when practicing clinicians echo the treatment they received as students to those now in their charge. Such a phenomenon is not necessarily surprising, nor is it necessarily bad, given the generations of competent medical practitioners that have emerged from our teaching institutions. But we must be wary of whether educational practices foster environments of disrespect so that the capacity for empathy is not lost in the quest for competency.

In subjecting himself to this fate, the Hanged Man also demonstrates a sacrifice of ego. Though the details of the associated arcane symbolism are not of great relevance to the practice of medicine, the general principles of sacrificing ego and coming together to create something greater than the sum of its parts are certainly applicable. Successfully navigating the wards also requires a sense of humility and a will to help both patients and all other members of the health care team. As medicine becomes ever more specialized, effective teamwork is imperative in securing the future of positive clinical outcomes. The bullying that occurs in the health care setting has been identified as a major block to achieving this goal. If a culture of disrespect is impressed upon physicians in training, then the cycle is likely to continue. As Leape et al. once again say, “Everyone suffers in an atmosphere of intimidation. A hostile work environment lowers morale, creates self-doubt, and is a cause of burnout” [12].

Discussion and analysis of art have been used to enhance communication among colleagues and to circumvent some of the aforementioned issues of power abuse and maltreatment associated with contemporary clinical practice [9, 10, 12]. In this

regard, art provides an avenue for health care teams to achieve goals beyond the reach of individuals working in isolation.

The abundant foliage adorning the tree from which the man is hung suggests that his situation, though seemingly unfortunate, will actually be fruitful. A similar outlook can be ascribed to *Le Pendu*, in which living vines and healing hands symbolize hope and progress. Despite the ongoing prevalence of mistreatment within medical education, much is being done to combat it. The spectrum of medical student bullying is wide indeed, and it is important to remember that the stern words of an attending may stand as a beneficial learning experience. Finding a healthy mean between hierarchical assertions of power and sheltering medical students from the high-stakes and often-stressful life of a physician is a lofty, but necessary task. We must hope that, when future generations of medical students are “turned on their heads” in clinical years, their newfound perspectives will be imbued with enlightenment and empathy for patients and colleagues alike.

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MEDICAL NARRATIVE

Teaching by Humiliation—Why It Should Change

Jonathan Belsey, MBBS

Ten years ago, a survey of 2,316 medical students in 16 US medical schools revealed that 84 percent had been the subject of belittlement in the course of their training and 42 percent considered that their treatment had amounted to harassment [1]. The sources of the harassment and belittlement included fellow students, nurses, and patients, but by far the most significant source was qualified doctors, ranging from residents to professors. In this regard, the observations of the survey reflect a longstanding approach to medical education that is common to developed countries throughout the world.

I underwent my medical training in the UK in the early 1980s under a regime that seems to have evolved little over the subsequent 30 years. The sense of dread that surrounded us as the professor's teaching ward round approached was a feeling I can still recall with uncomfortable clarity. As we moved from patient to patient, we each prayed that we would not be the one targeted for humiliation that day. As the smirking audience of junior doctors, therapists, pharmacist, ward sister, and (worst of all) student nurses looked on, my heart would sink as I heard the dreaded words: "So, Belsey, what can you tell us about the problem this patient has?"

You knew that however well you presented the case, somewhere along the line you would trip up and give the predatory professor his opportunity to expose your inadequacies. Sometimes it would be your lack of medical knowledge; sometimes the question that you failed to ask the patient that would have revealed the root of the problem, or sometimes your ineptitude at eliciting the required clinical signs. On one memorable occasion, when I had appeared to cover all the bases clinically, the professor turned to me and berated me for attending his ward round wearing a plaid shirt that was clearly inappropriate for an aspiring doctor.

But for all the grandstanding of the professors, I think we understood that humiliating the students was all part of the show and was rarely meant personally. However embarrassing it was, I'm not sure that it did me any great psychological harm. Far more difficult to deal with was the low-grade bullying of the junior doctors—perhaps only a couple of years older than we were, they had yet to achieve sufficient self-confidence to relax in the presence of students. In our hospital the students had the dubious distinction of having to wear a waist-length white jacket, while the fully qualified staff sported their badge of office—the full-length white coat. This visible difference served to underline the chasm of knowledge and skills that seemed to divide us. These junior doctors appeared impossibly competent to us,

loved to flaunt their superior knowledge in front of both patients and ward staff, and made sure this was underlined by our failure to achieve the simple practical tasks that they set us. I wondered how it was that they could set up an IVI in a couple of minutes, while I struggled for half an hour to gain venous access, sweating and blushing as I apologised to the poor patient nursing multiple perforations from my failed attempts. I darkly suspected that the junior doctor would check out the patients in advance and make sure that I was only given those with calcified or collapsing veins to practice on, while reserving for herself those with whom rapid success was guaranteed.

Emerging from my years of training and walking onto the ward with my brand-new name badge with the magical prefix “Dr.,” I promised myself that I would never descend to humiliating the students assigned to help me—not least because I was uncomfortably aware that my own knowledge scarcely exceeded theirs. And yet, within a few months, I found myself emulating my erstwhile tormentors—using all the tactics that had made the past few years such misery. I would stand in the crowd on the professor’s ward round, enjoying the discomfort of the new students as they struggled to meet the impossible standard. I would send a student to clerk in a new admission, knowing full well that the old familiar alcoholic patient that he or she had been sent to see would bury the few facts relevant to his diagnosis in a sea of garrulous irrelevance, keeping the student busy for an hour or more without providing any insight into the underlying problem. I would even play the tedious gags on them that every student had to suffer—check the pedal pulses on a double amputee, observe the fundi on someone with a glass eye, interpret the ECG with the limb leads reversed.

I asked myself, “Why am I doing this?” and the awful truth gradually dawned—because it works.

Many years later, I was asked to take part in a TV show in which a group of final-year medical students were put through a week of 1950s-style ward training. In essence, we subjected them to a traditional regime of education by humiliation in which, although to some extent artificially staged for the TV cameras, the action was unscripted and was treated seriously by all concerned.

At the outset, the students had a good grasp of the basic skills required to take a history and examine a patient, but most of them struggled to place the information gathered into any sort of diagnostic framework. After a week of being put on the spot and being forced to face up to the shortcomings of their thought processes on camera, their approach to the task was dramatically transformed, enabling them to present the information clearly and systematically and arrive at a rational and justifiable differential diagnosis. Although the show itself was a trivial exercise in daytime TV entertainment, several students told me later that they actually found the experience useful and that it sharpened their performance as they went through their final examinations.

So, if belittlement works, why should we decry its use? The answer is clear—ends do not necessarily justify means. If you beat children every time they misbehave, they will soon stop misbehaving (at least in front of you). This is the power of negative reinforcement—does that mean that child beating is acceptable? Equally, should we endorse traditional student humiliation on the grounds that it works and makes them better doctors? Even if true, I would say not.

Slavishly following traditional educational methods, on the grounds that “it worked when I was at medical school and didn’t do me any harm,” demonstrates a degree of moral vacuity that demeans the medical profession. As scientists and adherents to evidence-based philosophy, we should have the skills to collate and analyze data relating to educational methods in order to define a new teaching paradigm that can achieve our goals without resorting to the philosophy of the playground.

The real challenge will then be to implement the changes. Unless and until there is sufficient demand to change an apparently successful strategy for an unfamiliar approach, we are unlikely to see a significant change in practice. To catalyze change, the next generation of trainers will have to acknowledge both that the problem exists and that it is amenable to change, before they have a chance to be corrupted by the old methods and assumptions. The next generation of trainers is, of course, you.

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Suggested Readings and Resources

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