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POSITION PAPER

Mistreatment Support within Clinical Learning Environments

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PREFACE

This position paper was adapted from an anti-racism student initiative by the authors and other colleagues. In addition to the anti-racism context, the authors acknowledge the ubiquity of mistreatment in the clinical learning environment and in this paper, have addressed the topic of mistreatment in general. The authors also acknowledge that specific marginalized groups have unique, intersectional needs to address mistreatment towards them and that further research would be necessary to comprehensively address these needs. Interventions should always be carried out by experts in the field and their guidance; thus, the recommendations serve as areas that experts should be consulted and recruited to oversee. The specifics of the interventions are left to the guidance of the experts as not doing so risks disregarding the unique needs and resources of the institution. We hope that this position paper can serve as a starting point for this conversation.

INTRODUCTION

Mistreatment is defined by the American Association of Medical Colleges (AAMC) as “an intentional or unintentional event that occurs when behaviour shows disrespect for the dignity of others and unreasonably interferes with the learning process”. According to the AAMC, examples 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 (1). At times, such experiences of mistreatment can be classified as microaggressions, which are defined as subtle actions, words, or behaviours enacted towards marginalized groups that may arise from unconscious biases, prejudices, or hostility, and ultimately lead to serious and negative impacts on the psychological well-being of the recipient (2, 3).

Visibility of minority status correlates with marginalization and mistreatment, particularly in ethnic and immigrant groups in Canada (4). Medical trainees from cultural and ethnic minority groups often encounter subtle and overt forms of racism throughout

their medical training, but often refrain from reporting these instances. While such experiences are reported across all years of medical school training, the Graduate Questionnaire (GQ) administered by the AAMC found that racially driven mistreatment of trainees was particularly prevalent during the clinical learning or clerkship years of medical school, particularly driven by the underlying hierarchy in medical training (5). Students from racialized backgrounds in Canadian and international medical schools have echoed similar experiences of “everyday racism” in both clinical and non-clinical learning, citing feelings of “otherness”, exclusion, and fear as barriers to vocalizing their experiences (5, 6, 7). Without adequate support, students from racialized and other marginalized communities are at greater risk for burnout (8).

Studies have found that the experiences of trainees earlier in clinical learning shaped their perception of their professional identities and the culture of medicine, a process often referred to as the “hidden curriculum” (9). Repeated experiences of mistreatment often lead to desensitization and a belief that some amount of abuse is a normal part of medical training (9, 10). Despite the extensive literature on the prevalence of learner mistreatment in clinical environments and the long-term consequences of repeated mistreatment, there remain few documented efforts to examine the implementation or effectiveness of learner supports during clerkship in Canada (10, 11, 12).

Our paper examines existing support for clinical learners at medical schools in Canada and the USA and provides recommendations to undergraduate medical education programs and hospital leadership to improve the clerkship experience of learners. This paper also sheds light on some of the unique challenges learners with marginalized identities face when encountering and addressing mistreatment in the clinical setting. Our recommendations are based on a literature search of institutional efforts to reduce medical learner mistreatment in both official and unofficial learning environments.

PRINCIPLES

The Ontario Medical Students Association makes its recommendations using the following guiding principles:

1. All individuals in the workplace can potentially contribute to student mistreatment, including peers, staff, faculty, and patients.
2. Educators, students, and healthcare professionals should receive training to identify their implicit biases and their impact on interprofessional relationships with learners from marginalized communities.
3. Medical schools and hospital training materials should prepare medical students to respond to mistreatment in the workplace.
4. Learners from marginalized communities should have access to culturally safe supports within their clinical learning environments.

RECOMMENDATIONS

Recommendation 1: Hospital training procedures and medical education should incorporate preventative measures for all potential sources of mistreatment towards medical learners, including from peers, staff, and patients.

Medical learner mistreatment can come from many different sources. One potential source of mistreatment is from peers, which can be addressed through the pre-existing, structured educational setting. Medical schools should implement education on unconscious bias, microaggressions, and discrimination prior to the start of clinical placements. The goals of this education include the ability to identify microaggressions, understand the consequences of microaggressions, and accept the responsibility of overcoming discriminatory biases (13). Current literature on such education suggests that a combination of didactic teaching, small-group discussions, informative resource distribution, and reflection exercises can be effective (14, 15, 16, 17, 18). Learners' understanding should be monitored to evaluate the efficacy of the intervention. To enact this recommendation, the OMSA should advocate to the Association of the Faculties of Medicine of Canada for the above educational content to be a mandatory component of the curriculum in Ontario medical schools and make it a standard for accreditation.

Residents and attending staff should also be trained to prevent the mistreatment of medical learners. A systematic review showed residents to be the third most common and consultants to be the first most common source of abuse to medical students with a prevalence of 15.6% and 34.4% respectively (19). Due to the power differential between learners and supervisors, learners are especially prone to experiencing mistreatment from residents and staff with few options for recourse. As such, preventative strategies are key before residents and staff develop identities in the workplace through the hidden curriculum that is complacent to such mistreatment (20, 21, 22). To address learner mistreatment early on in physicians' careers, training programs that define unacceptable conduct and clarify the magnitude of the issue should occur during resident orientation and faculty development (23, 24). Early intervention is critical as current literature suggests that while educational interventions are important, they do not have a significant independent impact on changing behaviours that are already present (25). A superior multi-faceted approach includes an effort to increase awareness, such as through faculty recognition awards for promotion of learner-supportive workplace culture or transparent dissemination of mistreatment data (23, 24, 26). Awareness can contribute to not only a decrease in incidents of mistreatment but also result in better reporting and incident review. Medical schools and hospitals should collaborate to organize these potential interventions. The OMSA should support students, residents, and staff in advocating their respective institutions for these mistreatment prevention strategies and can also potentially implement faculty recognition awards of their own.

Patients are also a source of learner mistreatment that should be considered. A systematic review showed patients or their families to be the second most common source of abuse to medical students with a prevalence of 21.9% (19). The WHO recommends that a clear policy statement should be put in place that declares non-tolerance for physical or verbal violence or discrimination in the workplace or

institution (27). Although it can be difficult to remove medical students from patients' care once these incidents arise, preventative measures include adequate security structures to enable escape from violent situations and anticipatory guidance training to increase situational awareness of the need to find help or temporarily remove themselves from the patient encounter (28, 29, 30, 31). In addition to primary preventative measures, secondary preventative measures to reduce negative impact include a robust learner support system that includes debriefing opportunities and knowledgeable staff who can be relied on for help during the mistreatment event (32, 33). Medical schools and hospitals should collaborate to organize these preventative measures from an educational and policy standpoint. The OMSA should support student advocacy efforts on these policies and can potentially offer their own resources for students that increase their ability to manage mistreatment scenarios.

Recommendation 2: Undergraduate medical education and clinical resources should educate learners on how to identify different types of mistreatment and enhance transparency in reporting policies to empower learners from marginalized communities to report instances of mistreatment.

Although there is substantial evidence to show that a vast proportion of medical students will encounter mistreatment during their training, societal pressure to conform to their roles within the professional hierarchy of medicine, lack of knowledge of institutional policies, and the perception that mistreatment is a normal part of medical training may hinder students from reporting mistreatment (10, 12, 34). Student mistreatment that continues to go unaddressed has been shown to lead to poor mental health outcomes and burnout (8). Due to the negative consequences of mistreatment on student well-being and professional identity, it is crucial for medical schools and associated clinical learning environments, such as hospital networks, to prioritize developing policies around - and educating learners about - mistreatment identification, reporting, and resolution.

Mistreatment can manifest in many settings and in many forms. Overt forms of mistreatment like verbal slurs or physical harassment are often easier to identify and more commonly reported than subtle forms of mistreatment such as microaggressions. However, both forms of mistreatment have been shown to have a substantial impact on student learning and well-being (8). As such, medical schools should adequately educate students on how to identify mistreatment in its various forms before clinical learning begins. Mistreatment education should include educating learners on defining, identifying, avoiding, and preventing the perpetuations of microaggressions. As mistreatment often goes unreported due to the inherent hierarchy in medicine, mistreatment education should emphasize how students can safely navigate inherent power differentials.

To ensure their appropriate use, mistreatment policies should be easily accessible and clearly outlined to students at the beginning of medical school and continually be reinforced. Fear of reprisal from implicated faculty or the institution and

doubt in the likelihood of appropriate resolution in the event of a conflict were found to be primary drivers of mistreatment reporting underutilization (34). Student experience offices within medical schools should prioritize developing avenues for students to report mistreatment from faculty, staff, colleagues, preceptors without fear of repercussions or identification. In focus groups conducted by Chung and colleagues (2018), many students voiced a lack of confidence in mistreatment reporting processes after failing to see appropriate responses from the school or faculty following reports. As such, medical schools and affiliated clinical learning environments should jointly strive to increase the transparency of reporting processes by outlining examples of behaviours that should be reported and the potential corresponding outcomes of such reports. We recommend that OMSA collaborate with Ontario medical schools to create and disseminate infographics outlining how to navigate mistreatment reporting procedures in each school.

Evaluating, evolving, and adapting existing procedures and educational tools to maximize student and faculty preparedness is crucial for a sustainable and successful mistreatment policy. Medical school programs should develop plans to continually and regularly review the culture of reporting to improve the safety of clinical learning environments for marginalized students. Institutions should collect metrics evaluating student response to mistreatment and internally distribute reports every two to four years. Based on these reports, they should adjust their policies using evidence-based best practices. Metrics should include (1) student, faculty, and staff knowledge around core principles of anti-oppression, cultural safety, and inclusion, (2) student perception of adequate support from the medical school during and after mistreatment reporting, and (3) student, faculty and staff knowledge of subtle and overt forms of mistreatment and discrimination. These evaluations should be shared with students to increase transparency and trust in the reporting process. We recommend that the OMSA should support student-led mistreatment and related policy research through the Medical Student Education Research Grant (MSERG) and highlight student contributions to the field. We also recommend that the OMSA collaborate with medical schools to highlight mistreatment policies that have been found to improve the student experience.

Recommendation 3: Clinical learning environments, including hospital and community-based settings, should ensure access to safe peer support for marginalized learners in clerkship and residency.

Although official mistreatment reporting systems should be developed in a way that removes the fear of reprisal, students may still feel more comfortable discussing incidents of mistreatment with trusted peers rather than reporting through official channels. A 2018 survey of third and fourth-year medical students at the David Geffen School of Medicine at UCLA found that students were less inclined to report experiences of mistreatment that were more nuanced, such as those typically labelled as microaggressions (34). Other barriers associated with underreporting include perceptions that medical culture inherently accompanies mistreatment, lack of importance placed on the offending incident, fear of damaging the professional

relationship, empathy with the source of mistreatment, and cumbersome reporting procedures that are time-consuming and lead to re-traumatization (34). As such, it is extremely important to acknowledge and address the need for safe spaces in which marginalized learners can connect with one another without the pressure to report mistreatment (5, 21).

Peer support is based on the belief that “people who have faced, endured, and overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations" (35). Although peer support is most commonly used to navigate mental health or addiction, it is becoming increasingly used as an intervention strategy by various institutions and organizations across all fields, including healthcare. For example, the use of peer support is encouraged by the Canadian Medical Association and Canadian Mental Health Association through their implementation of the “Wellness Connection”, which is a virtual, safe space where physicians and trainees can access various peer support resources, including virtual support group sessions led by trained facilitators (36, 37). In the context of mistreatment in clinical learning environments, peer supporters can act as non-judgmental listeners, allowing the speaker to feel valued and heard. They can also share coping strategies, advice, and insights from their own lived experiences (36). Furthermore, peer relationships are mutual and reciprocal in nature and incorporate friendship, connection, and equal power (38). All of these factors contribute to the well-documented positive outcomes of peer support including improved psychological resilience, self-determination, stronger social networks, and fewer feelings of isolation among participants (36, 39, 40, 41).

Practically, peer support initiatives for medical trainees experiencing mistreatment in clerkship or residency could be structured either formally or informally by medical schools. Formal peer support would involve employing peer workers or leaders to facilitate conversations with learners. For example, medical institutions can hire culturally competent experts in racial trauma to help trainees process their feelings and experiences with racialized mistreatment (42). A similar recommendation was recently made by Black nurses calling for designated Black counsellors to support Black and other racialized staff on the medical frontlines (43). While sharing an identity or lived experiences with trainees is not necessarily mandatory to be a successful group leader, having a trained facilitator who reflects the communities of people seeking support is highly recommended to create an environment that promotes healing while tackling challenging situations through a trauma-informed lens (44, 45).

Alternatively, informal peer support could take the form of small group sessions that provide students with authentic and safe spaces to verbalize and reflect on encounters of mistreatment with patients, peers, and healthcare staff (21). In developing these groups, the emphasis should be placed on bringing together students with common experiences and a shared understanding, as this can facilitate unique emotional identification and reduce feelings of isolation (46). In informal peer support groups, the members are equals, so participants may feel more comfortable discussing vulnerable interactions without the potentially intimidating presence of a counsellor or

facilitator (44). In these settings, it is essential to inform students of the importance of respecting their peers' confidentiality when sharing personal stories of mistreatment (17, 18). Importantly, medical schools should attempt to tailor these peer support groups to different marginalized identities, based on a thorough needs assessment conducted with data from previously reported incidents and feedback from working groups or relevant Equity, Diversity, and Inclusion (EDI) committees. Further, we recommend that the OMSA, through the Student Affairs, EDI and Advocacy portfolios, offer peer support programs to help medical trainees process their experiences of mistreatment and seek avenues and resources for support. Peer support should become an essential part of the continuum of care for medical trainees, alongside reliable reporting systems for mistreatment and education on preventative measures.

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REFERENCES

1. Mavis B, Sousa A, Lipscomb W, Rappley MD. Learning about medical student mistreatment from responses to the medical school graduation questionnaire. Acad Med. 2014;89(5):705-11.
2. Babla K, Lau S, Akindolie O, Radia T, Modi N, Kingdon C, et al. Racial microaggressions within respiratory and critical care medicine. The Lancet Respiratory Medicine. 2021;9(3):e27-e8.
3. Periyakoil VS, Chaudron L, Hill EV, Pellegrini V, Neri E, Kraemer HC. Common Types of Gender-Based Microaggressions in Medicine. Academic Medicine. 2020;95(3):450-7.
4. Simpson L. Violent victimization and discrimination among visible minority populations, Canada, 2014. Juristat. 2018:1-17.
5. Pradhan A, Buery-Joyner SD, Page-Ramsey S, Bliss S, Craig LB, Everett E, et al. To the point: undergraduate medical education learner mistreatment issues on the learning environment in the United States. American Journal of Obstetrics and Gynecology. 2019;221(5):377-82.
6. Kristoffersson E, Rönnqvist H, Andersson J, Bengs C, Hamberg K. "It was as if I wasn't there" – Experiences of everyday racism in a Swedish medical school. Social Science & Medicine. 2021;270:113678.
7. Beagan BL. 'Is this worth getting into a big fuss over?' Everyday racism in medical school. Medical Education. 2003;37(10):852-60.
8. Cook AF, Arora VM, Rasinski KA, Curlin FA, Yoon JD. The prevalence of medical student mistreatment and its association with burnout. Acad Med. 2014;89(5):749-54.
9. Kulaylat AN, Qin D, Sun SX, Hollenbeak CS, Schubart JR, Aboud AJ, et al. Perceptions of mistreatment among trainees vary at different stages of clinical training. BMC Medical Education. 2017;17(1):14.
10. Gan R, Snell L. When the learning environment is suboptimal: exploring medical students' perceptions of "mistreatment". Acad Med. 2014;89(4):608-17.
11. Mocanu V, Kuper TM, Marini W, Assane C, DeGirolamo KM, Fathimani K, et al. Intersectionality of Gender and Visible Minority Status Among General Surgery Residents in Canada. JAMA Surgery. 2020;155(10):e202828-e.
12. Bell A, Cavanagh A, Connelly CE, Walsh A, Vanstone M. Why do few medical students report their experiences of mistreatment to administration? Medical Education. 2021;55(4):462-70.

13. Sue DW, Capodilupo CM, Torino GC, Bucceri JM, Holder AMB, Nadal KL, et al. Racial microaggressions in everyday life: Implications for clinical practice. American Psychologist. 2007;62(4):271-86.
14. Acholonu RG, Cook TE, Roswell RO, Greene RE. Interrupting Microaggressions in Health Care Settings: A Guide for Teaching Medical Students. MedEdPORTAL. 2020;16(1):10969-.
15. DallaPiazza M, Padilla-Register M, Dwarakanath M, Obamedo E, Hill J, Soto-Greene ML. Exploring Racism and Health: An Intensive Interactive Session for Medical Students. MedEdPORTAL. 2018;14(1):10783-.
16. Sandoval RS, Afolabi T, Said J, Dunleavy S, Chatterjee A, Ölveczky D. Building a Tool Kit for Medical and Dental Students: Addressing Microaggressions and Discrimination on the Wards. MedEdPORTAL : the journal of teaching and learning resources. 2020;16:10893-.
17. Chow Candace J, Case Gretchen A, Matias Cheryl E. Tools for Discussing Identity and Privilege Among Medical Students, Trainees, and Faculty. MedEdPORTAL. 2019;15.
18. Brooks Katherine C, Rougas S, George P. When Race Matters on the Wards: Talking About Racial Health Disparities and Racism in the Clinical Setting. MedEdPORTAL. 2016;12.
19. Fnais N, Soobiah C, Chen MH, Lillie E, Perrier L, Tashkhandi M, et al. Harassment and Discrimination in Medical Training: A Systematic Review and Meta-Analysis. Academic medicine. 2014;89(5):817-27.
20. Kassebaum DG, Cutler ER. On the culture of student abuse in medical school. Academic medicine. 1998;73(11):1149-58.
21. Thomas B, Booth-McCoy AN. Blackface, Implicit Bias, and the Informal Curriculum: Shaping the Healthcare Workforce, and Improving Health. Journal of the National Medical Association. 2020;112(5):533-40.
22. Fallin-Bennett K. Implicit Bias Against Sexual Minorities in Medicine: Cycles of Professional Influence and the Role of the Hidden Curriculum. Academic medicine. 2015;90(5):549-52.
23. Fried JM, Vermillion M, Parker NH, Uijtdehaage S. Eradicating medical student mistreatment: a longitudinal study of one institution's efforts. Acad Med. 2012;87(9):1191-8.
24. Smith-Coggins R, Prober CG, Wakefield K, Farias R. Zero Tolerance: Implementation and Evaluation of the Stanford Medical Student Mistreatment Prevention Program. Academic psychiatry. 2017;41(2):195-9.
25. Mazer LM, Bereknyei Merrell S, Hasty BN, Stave C, Lau JN. Assessment of Programs Aimed to Decrease or Prevent Mistreatment of Medical Trainees. JAMA Network Open. 2018;1(3):e180870-e.
26. House JB, Griffith MC, Kappy MD, Holman E, Santen SA. Tracking Student Mistreatment Data to Improve the Emergency Medicine Clerkship Learning Environment. The western journal of emergency medicine. 2018;19(1):18-22.
27. International Labour Organization, International Council of Nurses, World Health Organization, Public Services International. Framework Guidelines for Addressing Workplace Violence in the Health Sector: International Labour Office; 2002.
28. Vento S, Cainelli F, Vallone A. Violence Against Healthcare Workers: A Worldwide Phenomenon With Serious Consequences. Frontiers in Public Health. 2020;8(541).
29. Raveel A, Schoenmakers B. Interventions to prevent aggression against doctors: a systematic review. BMJ Open. 2019;9(9):e028465.
30. Zhu G, Tan TK. Medical student mistreatment by patients in the clinical environment: prevalence and management. Singapore medical journal. 2019;60(7):353-8.
31. Wilkins KM, Goldenberg MN, Cyrus KD. ERASE-ing Patient Mistreatment of Trainees: Faculty Workshop. MedEdPORTAL. 2019;15:10865.
32. Wheeler DJ, Zapata J, Davis D, Chou C. Twelve tips for responding to microaggressions and overt discrimination: When the patient offends the learner. Medical teacher. 2019;41(10):1112-7.
33. Whitgob EE, Blankenburg RL, Bogetz AL. The Discriminatory Patient and Family: Strategies to Address Discrimination Towards Trainees. Academic medicine. 2016;91(11 Association of American Medical Colleges Learn Serve Lead: Proceedings of the 55th Annual Research in Medical Education Sessions):S64-S9.
34. Chung MP, Thang CK, Vermillion M, Fried JM, Uijtdehaage S. Exploring medical students' barriers to reporting mistreatment during clerkships: a qualitative study. Med Educ Online. 2018;23(1):1478170.

35. Davidson L, Chinman M, Sells D, Rowe M. Peer support among adults with serious mental illness: a report from the field. Schizophr Bull. 2006;32(3):443-50.
36. Peer Support: Canadian Medical Association; Available from: https://www.cma.ca/physician-wellness-hub/topics/peer-support.
37. 5 Things to Know About Peer Support: Canadian Mental Health Association; 2018 Available from: https://cmhawwselfhelp.ca/news/5-things-to-know-about-peer-support/.
38. Forchuk, Jewell, Schofield, Sircelj, Valledor. From hospital to community: Bridging Therapeutic Relationships. Journal of Psychiatric and Mental Health Nursing. 1998;5(3):197-202.
39. Agarwal B, Brooks SK, Greenberg N. The Role of Peer Support in Managing Occupational Stress: A Qualitative Study of the Sustaining Resilience at Work Intervention. Workplace Health Saf. 2020;68(2):57-64.
40. Cyr CI, McKee H, O'Hagan M, Priest R. Making the Case for Peer Support: Report to the Peer Support Project Committee of the Mental Health Commission of Canada. Mental Health Commission of Canada, Committee MHPSP; 2016.
41. Davidson L, Bellamy C, Guy K, Miller R. Peer support among persons with severe mental illnesses: a review of evidence and experience. World Psychiatry: official journal of the World Psychiatric Association (WPA). 2012;11(2):123-8.
42. Neal-Barnett A. How Organizations Can Support the Mental Health of Black Employees. Race [Internet]. 2020. Available from: https://hbr.org/2020/06/how-organizations-can-support-the-mental-health-of-black-employees.
43. Walker I. 'You have patients say the N-word': Black nurses call for support against racism on the medical frontlines'. 2021. Available from: https://www.cbc.ca/radio/whitecoat/you-have-patients-say-the-n-word-black-nurses-call-for-support-against-racism-on-the-medical-frontlines-1.5964656.
44. Implementing Promising Community Interventions. Center for Community Health and Development at the University of Kansas. Available from: https://ctb.ku.edu/en/table-of-contents/implement/enhancing-support/peer-support-groups/main.
45. What to Expect from a GPS Support Group [Internet]. Group Peer Support. Support Groups Central; Available from: https://www.supportgroupscentral.com/clt_addtllinks_cd.cfm?rno=155&cid=51&CFID=4147847&CFTOKEN=7ee29a7609c733c6-518E8056-FA52-87F9-6B7C177EDEED6A09
46. Gray RE, Fitch M. Cancer self-help groups are here to stay: Issues and challenges for health professionals. Journal of palliative care. 2001;17(1):53-8.