INTIMIDATING BEHAVIOUR TOWARDS MEDICAL STUDENTS IN THE CLINICAL ENVIRONMENT
Report and Recommendations from an Otago Medical School Workshop held in Dunedin on 15/12/15

1. Introduction

A workshop was organised after an approach to the Otago Medical School (OMS) by student representatives about the issue of bullying in medical education. The aims of the workshop were to generate cohesive policy and process around the issue, and for the Otago Medical School to articulate an agreed stance, given recent publicity. The number of attendees at the workshop was deliberately restricted. The initial draft report was circulated widely for comment. A small group then met and amended the original report to reflect the consultation responses. This final agreed document is now presented for approval of the recommendations.

The report and its recommendations are intended to clarify the stance of the Otago Medical School in relation to bullying behaviour towards students, and support students with an effective informal process that gathers information, protects students from prejudice because of reporting, and is in addition to formal processes within the University and DHBs, which are the pathways to laying formal complaints. Particularly, the processes outlined are in addition to, and not in replacement of, the Ethical Behaviour Policy of the University of Otago.

The Ethical Behaviour Policy sets out University wide informal and formal processes. Appendix 2 in the Ethical Behaviour Policy document describes available informal processes, including the work of the University Mediator and the availability of the Ethical Behaviour Network, who are a group of Otago staff and students who are trained to provide a first point of contact for anyone who has concerns. The members of the contact network won’t tell a student what to do but they will provide a safe place to talk through concerns and identify options.

Contact Network in Wellington
Contact Network in Christchurch
Contact Network in Dunedin
Contact Network in Southland

2. Attendees

Attendees present at the original workshop were:

Professor Peter Crampton, Dean Otago Medical School (Facilitator)
Dr John Adams, Associate Dean Student Affairs, OMS
Dr Lynley Anderson, Senior Lecturer, Bioethics Centre
Ms Lauren Barnett, Trainee Intern MB ChB, DSM
Ms Malia Begley, Trainee Intern MB ChB, DSM
Mr Kieran Bunn, 4th Year MB ChB, UOW (attended by teleconference)
Ms Emily Dwight, 4th Year MB ChB, UOW
Mr Mike Fleete, Trainee Intern MB ChB, UOW (attended by teleconference)
Dr Ben Gray, Senior Lecturer, Primary Health Care & General Practice, UOW
Associate Professor Jan McKenzie, Associate Dean Student Affairs, UOC
Dr Mary Leigh Moore, Senior Lecturer & Simulation Centre Director, UOC
Ms Kim Noah, 4th Year MB ChB, UOC
Dr Kelby Smith-Han, Teaching Fellow, OMS
Mrs Lyn Smith, 4th & 5th year and MEG Administrator, DSM
Ms Maddy Tagg, Trainee Intern MB ChB, UOC
Ms Ann Thornton, Student Affairs Administrator, UOW
Mrs Jillian Tourelle, Manager Student Affairs, OMS
Professor Tim Wilkinson, Director MB ChB Programme, OMS
Dr Sue Walthert, Associate Convenor Professional Development, DSM

Apologies:
Dr Joanna MacDonald, Associate Dean Student Affairs, UOW (due to illness)
Dr Hamish Wilson, Early Learning in Medicine, OMS
3. Summary of Recommendations

The meeting reiterated the Otago Medical School’s position that safe and supportive learning environments are the cornerstones of quality learning, and that intimidating or abusive behaviour towards students has no place in modern medical education.

a) Safe pathways for reporting:

• Policy
  1. Reports about intimidating behaviour in the teaching environment should be encouraged and will be collated and retained in one place. Students and others can report through a number of channels.

• Procedures
  1. The various pathways should be made known to all staff and students.
  2. An 'incident reporting form' should be created and made generally available.
  3. Students should be surveyed regularly and asked for feedback on both meritorious and intimidating teacher behaviour.
  4. Reports from multiple sources (see fig 1) will be passed to the Associate Dean of Student Affairs in the relevant School, who will be responsible for collating, recording and retaining reports.
  5. The processes through which such information is handled and interpreted should be made explicit to staff and students.

b) Processes and procedures once reported:

• Policy
  1. Reports of serious or egregious intimidating behaviour will be passed immediately to the relevant Dean, who will investigate and take action as appropriate.
  2. All other reports of intimidating behaviour (confidential but not anonymous) will be considered by an assessment group at each campus, chaired by an independent person, and further actions taken if, or when, an appropriate threshold has been reached.

• Procedures
  1. The relevant Dean will investigate reports of serious instances, and will involve the student, the HoD, HR, the Proctor or the DHB as necessary. Formal disciplinary action may need to be taken.
  2. An independent Chair will convene a Behaviour Assessment Team to consider all other new and existing reports as needed.
  3. The Chair will feedback to the person(s) reporting what action the team proposes to take.
  4. If the team decides that the appropriate threshold has been reached, and the person reporting is in agreement, this information will be passed to the relevant Dean, who together with the appropriate HoD or DHB management, may discuss the issue with the staff member concerned.
  5. Campuses will ensure that information about sources of support for those reporting are communicated clearly (e.g. on Moodle), and that students reporting receive appropriate guidance and support from Student Affairs.

c) How to change Cultures:

• Policy
  1. The Otago Medical School will support intervention and research initiatives in governance and operational areas that have the potential to improve the quality of learning environments.
  2. The Otago Medical School will initiate and support education for current teachers and students on constructive teaching methods.
4. Safe pathways for reporting

a) Intimidating behaviour:
The Otago Medical School’s position is that safe and supportive learning environments are the cornerstones of quality learning, and that intimidating or abusive behaviour towards students has no place in modern medical education.

This begs the question about what constitutes such behaviour in the teaching context. The University’s Ethical Behaviour Policy says:

(c) Unethical behaviour includes, but is not limited to, sexual harassment, racial harassment, discrimination, personal harassment and bullying, the abuse of supervisory authority and failing to declare or manage a conflict of interest.

The MCNZ’s Statement: “Unprofessional behaviour and the health care team. Protecting patient safety” says:

Such behaviours include but are not limited to:

- bullying or intimidation
- sexual harassment
- racial, ethnic or sexist slurs
- loud, rude comments
- intimidation, abusive or offensive language
- persistent lateness in responding to work calls
- throwing instruments
- offensive sarcasm
- threats of violence, retribution or vexatious litigation
- demands for special treatment
- passive aggression
- unwillingness to discuss issues with dependent colleagues in a cordial and respectful manner; including handover meetings.

In a teaching situation this includes behaviour that is aimed at humiliating students, particularly in front of others, for any reason, including the limits of their knowledge or competence.

Students accept that teachers questioning them to the boundaries of their knowledge, as in the ‘Socratic method’, is often a valuable learning exercise. However, the teacher’s behaviour once that boundary is reached, is crucial. Belittling or criticising the student at this point is not acceptable. Medical students, as senior University scholars, should expect to have their work and understanding challenged, but this has to be done in a way that leads to constructive learning.
b) Reporting Intimidating Behaviour:
The Otago Medical School fully endorses the absolute need for a system where instances of intimidating behaviour can be reported easily, with the student feeling supported and validated in their concerns. The Otago Medical School will also continue efforts to ensure that reporting intimidating behaviour has no impact on a student’s progress.

A student might first be able to confer with peers or other colleagues about the incident. Sometimes, additional perspective is gained in this way from others’ knowledge and understanding. Reporting is available through multiple differing channels. Within ELM, a student can approach their OUMSA representatives, their lecturers, tutors, convenors, administrative staff, Student Affairs or the ELM Director. In ALM a student can talk with their student representatives, the convenor of the attachment, the HoD, Student Affairs, the Dean, their mentor, or write about it in a TPER (Thought Provoking Episode Reports).

It is considered that a new form for providing reports of incidents should be made available. Students should regularly be asked for feedback and comment on any incidents of concern. The Otago Medical School therefore endorses the idea of regular (perhaps at least twice yearly) requests of students to provide any feedback about both meritorious and intimidating teacher behaviour.

There are, however, clear, and understandable, barriers to reporting:

1. The behaviour may not have reached a threshold where action is warranted – yet unless multiple sub-threshold incidents are recorded, patterns cannot be detected or acted upon.
2. Multiple pathways to reporting may make it easier to report but may also make it harder to know which pathway to use.
3. Students feel hesitant about reporting poor behaviour because of a fear about potential impacts on their academic progress, or because they lack confidence to know if it is serious enough. Sometimes students do not want to make a formal complaint, but want someone to know about intimidating behaviour, and have their feelings validated.
4. The distinctions between anonymous reporting and confidential reporting are not necessarily widely understood.
5. There can be a misplaced expectation that observing (or reporting) a behaviour must also be accompanied by a judgment or interpretation of that behaviour, and that such judgements must be made by the observer. However the observer may not be in a position to interpret or judge. This means there needs to be a separation between data collection (observation and reporting) and interpretation and judgement.

Reporting should be seen as being more usual – much as the clinical culture has moved to seeing quality and safety incident reports as being normalised methods to help raise standards of clinical care.

Bystanders (other clinical and general staff, and other students) have a critical role to play, and should also be encouraged to report instances where in their view, behaviour towards students was not satisfactory. Bystanders could choose any of the above ‘portals’ for input. An ‘incident form’ may also be of particular use for bystanders.

Unless reported behaviour of a single incident is particularly egregious, better data would come from keeping multiple reports and observations over time. In this way patterns of behaviour with individual people or services could be determined and acted on as needed.

Multiple pathways for reporting should lead to one final common pathway. The Associate Dean of Student Affairs (ADSA) should be responsible for collating and holding the information and presenting that information for review.

That review should take place by a well-informed group at each campus chaired by an independent person outside the Medical School and DHB.
Recommendations:

• Policy
  1. Reports about intimidating behaviour in the teaching environment should be encouraged and will be collated and retained in one place. Students and others can report through a number of channels.

• Procedures
  1. The various pathways should be made known to all staff and students.
  2. An ‘incident reporting form’ should be created and made generally available.
  3. Students should be surveyed regularly and asked for feedback on both meritorious and intimidating teacher behaviour.
  4. Reports from multiple sources (see Figure 1) will be passed to the Associate Dean of Student Affairs in the relevant campus, who will be responsible for collating, recording and retaining reports.
  5. The processes through which such information is handled and interpreted should be made explicit to staff and students.

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Figure 1

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General Staff

→ ADSAs

→ Convenors

→ PD Convenors → ADSAs

→ Student Leaders

→ Deans

→ Solicited Comments

→ Critical Incident reports
5. Processes and procedures once reported

'Closing the loop' with information received through the reporting process presents some interesting issues.

If the student (or other) wants to pursue a formal complaint, the matter can be passed from the ADSA to the Dean for investigation and further action, or, if University staff or other students are involved, the student can write directly to the Proctor. Formal complaints, through the requirements of 'natural justice', will mean that the identity of the student and what they are saying will be made available to the person about whom the complaint is made. Such a process is likely to be initiated for incidents which are clearly beyond an acceptable threshold.

Students often do not want to be identified, and sometimes do not feel that the situation is of such severity that it warrants a formal complaint. What is frequently wanted is some feedback to the perpetrator, or collation with other information, about their behaviour. One 'low level' complaint may mean little about the person’s usual behaviour. A series of complaints may begin to establish a pattern that has more substance.

The Otago Medical School is of the view that information collected over time that establishes a possible pattern in someone’s behaviour, should be fed back to them. Depending on the nature of the pattern of behaviours, this could be done in an informal way, probably by the Dean or HoD. e.g. “Several reports of instances of you saying things that might be construed as racial slurs have come to our attention – and we thought that you should know that this is a perception of you that is building.” However, some issues may need formal reporting mechanisms.

This raises the issue of assessing the information from the multiple sources and making a decision about whether this reaches a threshold that indicates that it should be passed to the School Dean, or HoD of the relevant Department for action. While the ADSAs hold the information, such decisions are best made by a group. In order for students to trust the process and believe that their reports will be taken seriously and not impact on their progress, that group should be chaired by an independent person at each campus. The Otago Medical School therefore proposes the establishment of a group (Behaviour Assessment Team), chaired by someone independent, meeting as needed, that would review new information that comes to hand, assess it against any existing information, and make the decision as to whether the threshold has been reached to pass the information on for informal action. (Figure 2) The group would also consider the best person or persons to pass the information on to.

The Chair of the group should feedback to the person(s) who have initiated the report what action is recommended, before taking such actions. This leaves the person in charge of the process, and ‘closes the loop’.

Support for the reporting person needs to be explicit and available. Student Affairs would normally take the lead role in ensuring that any student reporting intimidating behaviour has the required support in place. Sources of support should be well communicated to students.

Recommendations:

- **Policy:**
  1. Reports of serious or egregious intimidating behaviour will be passed immediately to the relevant Dean, who will investigate and take action as appropriate.
  2. All other reports of intimidating behaviour (confidential but not anonymous) will be considered by an assessment group at each campus, chaired by an independent person, and further actions taken if, or when, an appropriate threshold has been reached.
• Procedures:
1. The relevant Dean will investigate reports of serious instances, and will involve the student, the HoD, HR, the Proctor or the DHB as necessary. Formal disciplinary action may need to be taken.
2. An independent Chair will convene a Behaviour Assessment Team to consider all other new and existing reports as needed.
3. The Chair will feedback to the person(s) reporting what action the team proposes to take.
4. If the team decides that the appropriate threshold has been reached, and the person reporting is in agreement, this information will be passed to the relevant Dean, who together with the appropriate HoD or DHB management, may discuss the issue with the staff member concerned.
5. Campuses will ensure that information about sources of support for those reporting are communicated clearly on (e.g. on Moodle), and that students reporting receive appropriate guidance and support from Student Affairs.
6. How to change Cultures

Dealing with individuals is only a part of dealing with the issue of intimidating behaviour in the medical learning environment. Poor behaviour towards students is not limited to medicine as a profession, nor to doctors as individuals. Medical students can be on the end of intimidating or uncivil behaviour from other health professionals, managers, and administrative staff. Often such behaviour is tolerated by, or even encouraged by, the prevailing work culture. There is a significant task to change the way that things are done.

Furthermore, there is a need to ‘shift the bell shaped curve’ not just detect the ‘bad apples’. Identifying and celebrating meritorious behaviour, and encouraging bystanders speaking up are just some of the ways to do this.

The University is only a part player in any attempt to make things different. The environment and attitudes in both DHBs and Primary Care contribute majorly to the nature of learning environments.

An example of a move in this area is the recent initiative from RACS (Royal Australasian College of Surgeons), which has sent a powerful message about standards of expected behaviour not only to surgeons, but also to the public. Patients are deeply involved in this whole issue as one outcome of intimidating or uncivil behaviour is poor patient care.

Dr Lynley Anderson, Professor Tim Wilkinson, Dr Althea Blakey and Dr Kelby Smith-Han have initiated a research intervention project aimed at positively changing the quality of learning environments. This project grew out of an idea to establish a code of conduct for teachers. It was thought that generating ‘aspirational’ goals for learning environments, rather than focusing on individuals, and rewarding those that were achieving the goals would have greater impact. The project will be a joint project with Auckland Medical School, and will begin with an intervention in the Southern DHB. A brief description of this project is attached as appendix 1.

The Otago Medical School supports working with DHBs to change culture.

There are potential high level governance interventions with the DHB that could be pursued through the MoU process and the Joint Relations Committees, to set expectations about teaching and behaviour towards students. For instance, many years ago there was an initiative in Dunedin to have joint job appraisals for both University and DHB staff. This would mean that teaching performance could be a part of the appraisal for DHB staff. Currently, there is no formal mechanism for feedback on teaching performance for these staff. MoUs could specify aspirational goals for learning environments and that information on unprofessional behaviour should be shared between organisations.

Efforts to provide training and education sessions for staff across the University, DHBs and Primary Care on teaching methods, providing feedback and what makes a good learning environment should be strengthened. Consciousness should be raised about what is OK in teaching and what is not. The aim is to have learning environments that staff feel proud of belonging to.

Learning about teaching starts in Medical School. Greater efforts could be made to teach students about how to teach, so that the next generation of medical teachers is up skilled.

Students comment that they fear that teachers would pull back or pull out if they began to worry that there would be reprisals for their manner of teaching, and if they were unsure of what was acceptable.

Recommendations:

- Policy
  1. The Otago Medical School will support intervention and research initiatives in governance and operational areas that have the potential to improve the quality of learning environments.

  2. The Otago Medical School will initiate and support education for current teachers and students on constructive teaching methods.
7. Increasing student resilience in the working environment:

The meeting acknowledged that by its nature, the clinical environment can be challenging. Expectations of quality and excellence, as well as peer and colleague review are a usual part of ongoing quality assurance and improvement. Furthermore, stressful environments can create tensions that need to be recognised and handled in order to promote optimal clinical care.

Students at the meeting commented that some introduction to teaching methods, such as Socratic questioning, that are used (appropriately) in the clinical environment could be provided in ELM, so that students are prepared to be challenged and do not construe such methods as personal attacks. A little discomfort stimulates learning. Methods by which health professionals learn in workplaces can also have applicability to medical students.

Students also said that a transparent discussion at the beginnings of attachments about how they would be taught and the use of interrogation to find thresholds of knowledge would prepare them and leave all parties feeling valued. "This is the way that we do things here to increase your knowledge...."

The meeting supported the idea of interventions aimed at giving students skills to deal with challenging situations in the work environment.

Dr Sue Walthert (DSM PD Convenor) has with a DSM working group, developed a strand programme in the Professional Development vertical module, ‘Real Life Relationships, Learning to work together in complex work environments’. This programme represents an educational response to the issues of intimidating behaviours at medical school. The development of the programme was supported by DSM. A final proposal is in the process of being assessed. It contains learning opportunities in three arenas: lectures and seminars on cognitive knowledge about working together in complex work environments; new “ACYST” groups on relational challenges that will replace and upgrade mentoring groups; and initiatives in the institutional or environmental arena. ACYST stands for ALM Clinical Year Support Training groups. ACYST groups will provide students with regular opportunities to review their learning experiences, cognitive rehearsal of different ways of relating with others, and will also have an objective to develop understanding of doctor/patient relationships. Such a change will require curricula time and an increase in the PD budget enabling ACYST Fellows to be suitably up skilled and supported. The proposal is currently being considered by the Dean, Professor Barry Taylor. If implemented and successful, the key elements of this proposal should be made known to other ALM sites in order to adapt and implement similar initiatives.

Recommendations:

- **Policy**
  1. ALM Campus Schools will provide programmes that support and up skill students in learning and dealing with challenges in the clinical environment.

- **Procedure**
  1. MCC will evaluate initiatives in the area introduced in Schools and determine what could be implemented in a consistent manner across ALM Campus Schools.
CAPLE PILOT STUDY
Creating a Positive Learning Environment

The CAPLE project aims to work with clinical staff to improve the atmosphere and workplace environments to make them even more conducive to learning for all health students in clinical practice.

The project is being undertaken by staff at the University of Otago, School of Medicine, and the Otago Polytechnic, (Appendix 1) with the support of other researchers at the University of Auckland, School of Medicine. Health professional students commonly describe mixed experiences in their interactions with staff within busy clinical areas. These experiences both positive and negative are described within the literature by students both internationally and nationally. Recent media reports from the NZMSA and the Royal Australasian College of Surgeons attest to the fact that not all students fare well during their training. The toll on students can be significant, from doubts about career choice, failure to learn, stress and mental health issues, and fostering persistent negative behaviours to the next generation of students. The CAPLE researchers have a primary focus on improving the learning environment for all health students.

A positive learning environment
Our focus is on cultivating a positive learning environment that welcomes students, clarifies their role, encourages collaboration, and provides constructive feedback to achieve the best learning space for tomorrow’s health workforce. Unfortunately a small number of students may encounter the other end of the spectrum, where negative behaviour may inhibit their learning. Such negative experiences might include bullying.

Our plan is not to focus on negative behaviours but to enhance and enable staff to be highly skilled practitioners in health education, and for students to flourish within the positive end of the spectrum.

Prior research that supports the current pilot study
To test the efficacy of our intervention, we need to gather data regarding current student experience across the medical and nursing school, and staff buy in and assistance.

Literature review 1
This review involved a systematic review of the literature about the prevalence and incidence of negative behaviours in clinical practice.

Literature review 2
Literature review 2, involved a systematic review of the literature about the success or otherwise of interventions used to combat negative behaviours. This review
emphasised that a positive and collaborative focus has the potential to achieve behaviour change. Information from this review informs the content and process of the pilot workshops.

Project summary

The proposed CAPLE pilot project is a mixed methods project using both survey and action research methods as described:

1. We will gather baseline data about current nursing (Otago Polytechnic) and medical student (University of Otago) experience using the NAQ-R and DREEM climate surveys. These surveys will be repeated regularly.

2. An Exemplar survey will provide local data on educational best practice as experienced by 5th year medical students, & 3rd year nursing students. Focus groups with staff from highly rated departments will identify examples of good practice that will inform the intervention.

3. The action research pilot intervention will involve a mix of 12 doctors and nurses from a DHB department. These participants will be allocated a named researcher, with whom they will foster a relationship of trust, in order to generate ideas for interventions that are feasible, and applicable in a wide variety of clinical workplace settings. We anticipate workshops may well form part of the intervention so we will suggest 4-5 workshops from which participants can choose. Workshops will be open to all staff from the area.

4. An ‘atmosphere’ survey (pre and post pilot) of clinical staff will detail changes over time for the duration of the pilot (12 weeks).

The success or otherwise of the action research pilot intervention will be determined by the analysis of the ‘atmosphere’ survey of staff and qualitative data collected about the intervention through transcribed interviews, emails from participants and reflective journals kept by participants.

Funding for this project has been provided by the Pro Vice Chancellor, Division of Health Sciences, University of Otago. Our focus is on cultivating a positive environment. This focus is supported by the international literature.

APPENDIX 1 – CAPLE Team members and experience

Prof Tim Wilkinson: Director, MB ChB programme (Faculty of Medicine), Deputy Dean (Christchurch). Geriatrician.

Associate Professor Lynley Anderson: Bioethics/Professional Development Convenor Early Learning in Medicine, Bioethics Centre, University of Otago. Previous experience as a physiotherapist.

Dr Kelby Smith-Han: Post-Doctoral Fellow, Medical Education, Anatomy Department, University of Otago. Previous experience as a psychologist.

Dr Althea Blakey: Post-Doctoral Fellow, Medical Education, Bioethics Centre, University of Otago. Previous experience as a radiation therapist.

Emma Collins: Senior Lecturer, School of Nursing, Otago Polytechnic. Current paediatric Nurse

Liz Berryman: 5th Year medical student, University of Otago. Previous experience as a nurse.
APPENDIX 2 - Definitions Bullying can mean unwanted and unwarranted behaviour that a person finds offensive, intimidating or humiliating and can be repeated so as to have a detrimental effect on a person’s dignity, safety and wellbeing. Examples of bullying can include:

- Physical (push, shove, hit)
- Verbal (called names, humiliated, insulted)
- Social (excluded, gossiped about, rumours spread, professionalism undermined)
- Racial (heard or received racist remarks)
- Sexual orientation/Gender identity (heard or received negative remarks about sexual orientation or gender identity)
- Gender (heard or received sexist remarks)
- Professional (e.g. failure to sufficiently prepare a staff member for a procedure, failure to listen to opinion, unreasonable requests).