**HOD ACTION: Council on Medical Education Report 9 adopted and the remainder of the report filed.**

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 9-A-13

Subject: Student Mistreatment

Presented by: Mahendr S. Kochar, MD, Chair

Referred to: Reference Committee C
(A. Patrice Burgess, MD, Chair)

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Perceived mistreatment by medical students is pervasive and consistent in medical education even after interventions to remedy it. Types of mistreatment include verbal abuse, sexual harassment, racial and ethnic insensitivity, abuse of power and physical abuse. Although public humiliation and belittlement are the most common forms of mistreatment, instances of physical abuse continue to occur.[1-3]

Mistreatment of students has been associated with lack of confidence in clinical skills, decreased empathy, increased cynicism about medicine, anxiety, depression, post-traumatic stress, drinking and suicidal ideation. Of concern is the potential for mistreatment to have long-lasting negative effects on students' professionalism and quality of patient care. [3-7]

Interventions to reduce mistreatment have included zero-tolerance policies, improved reporting structure such as the ability to file anonymous concerns, no statute of limitations, rewarding good behavior, focusing on maintaining a positive learning environment and disseminating best practices. Despite implementing these strategies, a culture of mistreatment persists. Recent findings from a study on student mistreatment at a US medical school found that despite interventions to eliminate mistreatment over a 13-year time period, students continued to report experiencing mistreatment during clerkships.[2]

## DEFINITION OF MISTREATMENT

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.[8]

## PREVALENCE OF MISTREATMENT

According to the 2012 Association of American Medical Colleges (AAMC) Graduation Questionnaire (GQ), almost half (47%) of medical students reported experiencing mistreatment. About one-third (34%) of respondents reported that they had been publicly humiliated at least once during medical school. About 16 percent (N = 1,935) were subjected to offensive sexist remarks and twelve percent (N = 243) were physically harmed.[1] Respondents to the 2012 GQ were 79 percent (N = 13,681) of medical students graduating from 126 LCME-accredited medical schools in the US in the 2011-2012 academic year.

The study further showed that students most often cited clerkship faculty (31%) in clinical settings, residents/interns (28%) and nurses (11%) as the perpetrators of mistreatment. The majority (85%) of medical students are aware that their school has a policy on mistreatment; about two-thirds (67%) know the procedures for reporting mistreatment at their schools. A relatively low percentage of students reported the incident, either when experienced personally (17%) or when witnessed happening to others (8%). The main reason for not reporting in both cases was "the incident did not seem important enough to report" (59% and 43% respectively). Among students who did report the behavior (either experienced personally or witnessed), over half reported the incident to a faculty member (52% and 55% respectively).[1]

It should be noted that between 2007 and 2011 about 17 percent of medical students reported being mistreated. The apparent reason for the large increase to 47 percent of students who reported being mistreated was a substantial revision to the questions regarding students' experiences of the various types of mistreatment in the 2012 GQ.

Before 2012, students were asked: Have you personally been mistreated during medical school? Students who answered "no" did not answer questions on whether or not they had personally experienced specific types of mistreatment. In 2012, this "gateway" question was removed and students were asked to respond to individual questions that pertained to specific behaviors associated with mistreatment. This change was implemented in part due to literature that indicates that questions on specific behaviors yields more accurate data than questions that require respondents to identify the behavior through the lens of a label, such as mistreatment.

Due to the changes made to the 2012 GQ questions on mistreatment, data from 2012 should not be compared to data from previous years of the GQ. For a detailed description of the changes and the specific questions on mistreatment see the section entitled "Changes to the GQ in 2012" and pages 41-44 respectively in the 2012 GQ All Schools Summary available online at: https://www.aamc.org/download/300448/data/2012gqallschoolssummaryreport.pdf.

## LCME STANDARDS MS-31-A AND MS-32

MS-31-A, the LCME accreditation standard on the medical education learning environment, went into effect in July 2009. In summary, the intent of the standard is for a medical school to:

1) Define the professional attributes that medical students are expected to develop;
2) Include education and student assessment related to these attributes as part of the educational program;
3) Evaluate the learning environment to identify positive and negative influences; and
4) Work with its partners to mitigate negative influences on medical students' development of desired professional attributes.

The wording of standard MS-31-A and its explanatory annotation are available online at: http://www.ama-assn.org/resources/doc/council-on-med-ed/cmereport4a11.pdf (see pages 20-21).

The LCME has an additional standard on the medical education learning environment, MS-32 that expects medical schools to define and publicize the standards for the teacher-learner relationship and to develop written policies for addressing violations. The wording of standard MS-32 and its explanatory annotation is available online at: http://www.ama-assn.org/resources/doc/council-on-med-ed/cmereport4a11.pdf (see page 21).

The LCME monitors compliance with this standard in part through responses to the AAMC GQ. The LCME co-chairs also wrote to the AMA and AAMC to ask for assistance in addressing mistreatment of medical students.

## ACTIVITIES OF THE AMA

In response to the request from the LCME to participate in addressing problems related to medical student mistreatment, the AMA Council on Medical Education (CME), the Section on Medical Schools, and the Medical Student Section held a joint education session entitled *Optimizing the Learning Environment: Exploring the Issue of Medical Student Mistreatment* during the 2011 Annual Meeting of the AMA House of Delegates. The AMA's commitment to reducing student mistreatment and promoting a positive medical education learning environment has led to three other AMA-sponsored activities: 1) Strategies for Addressing Medical Student and Resident Mistreatment Conference; 2) Medical Student Mistreatment: The Residency Connection educational session; and 3) the Learning Environment Study. For AMA activities that focus more broadly on the learning environment, refer to CME Report 4-A-11: Progress in Transforming the Medical Education Learning Environment. This report is available online at: http://www.ama-assn.org/resources/doc/council-on-med-ed/cmereport4a11.pdf.

### *Optimizing the Learning Environment: Exploring the Issue of Medical Student Mistreatment*

The AMA Council on Medical Education, Section on Medical Schools and the Medical Student Section (MSS) held a joint education program at the 2011 Annual Meeting. Speakers included representatives from medical schools, LCME and AAMC as well as members of the MSS and Resident and Fellow Section. The session brought together the perspectives of medical school deans, resident physicians, and medical students for the purpose of outlining the problem and suggesting potential solutions. A summary of the education session is available online at: http://www.ama-assn.org/resources/doc/medical-schools/sms-a11-mistreatment.pdf.

### *Strategies for Addressing Medical Student and Resident Mistreatment Conference*

The medical education learning environment including the relationship between teachers and learners is a long-standing interest of the CME. To further the AMA's commitment to reducing student mistreatment, the CME Subcommittee on Undergraduate Medical Education called for a conference.

This invitational conference was held November 30 – December 1, 2011. Participants were 30 experts in medical education, medical students, residents and AMA staff. Participants provided valuable feedback to the AAMC on enhancing the questions on mistreatment in the GQ. As a result of the conference, a new MSS listserv devoted to the topic of medical student mistreatment was created. The main purpose of the listserv was to provide specific feedback and suggestions to the AAMC on restructuring mistreatment questions on the GQ.

### *Medical Student Mistreatment: the Residency Connection*

The AMA also sponsored the educational session "Medical Student Mistreatment: The Residency Connection" at its 2012 Interim Meeting. The session highlighted the importance of addressing mistreatment of residents in the clinical setting before they enter unsupervised practice. Participants noted that the lack of a clear definition of mistreatment was a concern as this impacted the quality of data on mistreatment. Further, it was noted that what constituted mistreatment varied across

individuals making efforts to reduce mistreatment more complex. A summary of presentations from this educational session is available online at: http://www.ama-assn.org/resources/doc/medical-schools/i-12-sms-presentations.pdf.

*Learning Environment Study (LES)*

The AMA-led LES is a prospective longitudinal cohort study of the medical education learning environment. The LES includes approximately 4,800 medical students from 2 consecutive classes (2014 and 2015) representing 28 medical schools in the US and Canada. Students are being followed throughout the four years of undergraduate medical education. To measure the medical education learning environment, students complete the Medical School Learning Environment Scale (MSLES). Students complete a demographics questionnaire and four trait scales: Patient-Practitioner Orientation Scale (PPOS), Jefferson Scale of Physician Empathy, Ways of Coping Questionnaire, and Tolerance of Ambiguity Scale. Additionally, a representative from each participating school will complete the Structural Attributes of Schools Survey (SASS) to assess institutional-level factors that may influence students' perceptions of the learning environment including mistreatment.

The SASS includes the following two questions on mistreatment: 1) Is there a school policy to address student mistreatment? and; 2) What services are available to students who experience mistreatment and may wish to report it? Respondents are given the following list of services and are asked to check all that apply: a) Peer counseling; b) Support group for students who have experienced mistreatment; c) Ombudsman; d) Resolution mechanism at local level; e) Can report directly to a Dean /Associate Dean; and f) Other. Data collection for the SASS is scheduled for spring of 2013.

AMA POLICY ON MISTREATMENT

The recommendations and viewpoints stemming from the literature and AMA-sponsored meetings are highly consistent with existing AMA policy. The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints; (b) procedures for investigation; (c) protection and confidentiality; (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA also urges all medical education programs to regard the code of behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality (Policy H-295.955). The AMA specifically encourages the development of a model student orientation program that addresses standards of behavior for teachers and learners (Policy H-295.900).

The AMA has other related policies that address behavior in the educational context. Policy on professional behavior is detailed in the AMA's Principles of Medical Ethics (Policy E-1.001). The AMA has adopted principles to guide physician leaders of health care teams including fostering a respectful team culture (Policy H-160.912). Additionally, the AMA urges medical schools and residency programs to teach about ethics and the doctor-patient relationship (Policy H-295.961) as well as to promote professionalism, maintain a positive learning environment and provide appropriate role models for learners throughout medical school and residency training (Policies H-295.961, H-295.975, D-295.983).

## SUMMARY AND RECOMMENDATIONS

Reducing mistreatment must be addressed by a broad set of interventions. These include instituting polices, regulations or procedures to reduce behaviors associated with mistreatment, maintaining a positive learning environment, changing the culture of the medical profession, developing and rewarding models of good behavior and disseminating best practices, among others. Support from leadership is critical to creating and maintaining a positive learning environment. Changes in medical school culture to reduce mistreatment must include students. The AMA is committed to addressing the problem of student mistreatment and promoting a positive learning environment.

The Council on Medical Education recommends that the following recommendations be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-295.955, which recommends that each medical education institution have a widely disseminated policy that sets forth the expected standards of behavior of the teacher and learner and delineates procedures for dealing with breaches of that standard and specifies a Code of Behavior for all medical programs to utilize as a guide in developing standards of behavior for both teachers and learners. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-295.900, which encourages the development of a model student orientation program that addresses standards of behavior for teachers and learners. (Reaffirm HOD Policy)

3. That our AMA ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment. (Directive to Take Action)

4. That our AMA, through the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship. (Directive to Take Action)

5. That our AMA encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students. (Directive to Take Action)

Fiscal Note: Less than $500.

References


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3. Bursch B, Fried J M, Wimmers P F, Cook I A, Baillie S, Zackson H, Stumer M L. Relationship between medical student perceptions of mistreatment and mistreatment sensitivity. Med Teach. 2012;e1-e5.

4. Heru A, Gagne G, Strong D. Medical student mistreatment results in symptoms of posttraumatic stress. Acad Psychiatry. 2009;33(4):302-306.

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