Original Publication

⊟ OPEN ACCESS

Case Studies for Recognizing Appropriate and Inappropriate Behaviors in the Clinical Learning Environment

Howard B. Fleit, PhD*, Wei-Hsin Lu, PhD, Doreen M. Olvet, PhD, Latha Chandran, MD, MPH
*Corresponding author: howard.fleit@stonybrookmedicine.edu

Abstract

Introduction: The Association of American Medical Colleges surveys graduating medical students regarding the persistent prevalence of learning environment concerns. This training module is designed to increase awareness of appropriate and inappropriate behaviors in the clinical learning environment among medical professionals and trainees. **Methods:** An introductory PowerPoint presents the types of inappropriate behaviors that may be observed in the clinical learning environment along with institution-specific mechanisms for reporting such behaviors. We have also created six vignettes depicting various scenarios that trainees may encounter. The vignettes are presented in both text and video format and may be used in any combination. The entire module consisting of the PowerPoint presentation and the case studies can be delivered in 90 minutes to a large group of learners. Learners are divided into smaller groups of six to eight for discussions. The presentation and discussion can be done by a single or multiple facilitators. The target audience is primarily medical professionals and trainees at various levels of clinical exposure. **Results:** Since implementation of this training module at our institution, awareness of what constitutes mistreatment and how to report it has increased to nearly 100%. Representative institutional responses are provided for each vignette. **Discussion:** This training module can be presented to medical students, residents, and faculty at different stages of their professional development. We have enhanced learner awareness of what constitutes mistreatment and how to report these events. We offer these educational materials for other institutions to adapt and use in their specific institutional contexts.

Keywords

Clerkship, Mistreatment, Clinical Learning Environment

Appendices

A. The Learning Environment - Recognizing Appropriate and Inappropriate Behaviors.pptx

B. Case 1 - The Medical Student on Rounds.mp4

C. Case 2 - Requesting a Letter of Reference.mp4

D. Case 3 - The Operating Room.mp4

E. Case 4 - The Eager Medical Student.mp4

F. Case 5 - Social Media.mp4

G. Case 6 - The Nurse.mp4

H. Transcripts of Case-Study Videos.docx

All appendices are peer reviewed as integral parts of the Original Publication.

Educational Objectives

After completion of this module, learners will be able to:

1. Recognize medical student professional responsibilities in the clinical learning environment.

2. Recognize professional boundaries among teachers and learners.

3. Recognize and identify examples of abuse of power.

4. Recognize and identify gender and ethnically insensitive comments.

5. Identify institution-specific mechanisms to report mistreatment.

Introduction

An ongoing concern of the Association of American Medical Colleges (AAMC) and the Liaison Committee on Medical Education (LCME) has been medical students' perception of the learning environment. The results of several studies have prompted the AAMC to include questions regarding the learning environment in its annual Medical Student Graduation Questionnaire (MSGQ).[1-6] In addition, the LCME has incorporated specific standards into its accreditation process to ensure that all medical schools define appropriate standards of conduct between teachers and learners of medicine, develop programs to prevent inappropriate behaviors, and have mechanisms in place to address student complaints in a confidential and nonretaliatory manner. Incidents of public humiliation, belittlement, and sexual and racial

AAMC

harassment are frequently reported in the MSGQ data.[3,6] Such behaviors have consistently been associated with attending physicians, residents, and nurses.[3,6] More recent studies of trainees and health sciences faculty confirm that these inappropriate behaviors continue to occur in the clinical learning environment.[7-10] While educational activities, along with the creation of policies to try to reduce these behaviors, have been put in place globally, the issue of medical student mistreatment remains a concern.[11-15]

We designed a program called We can Eradicate Student Mistreatment in the Learning Environment (WE SMILE) to enhance awareness of medical student mistreatment in the clinical learning environment.[16] Initially, we developed a set of six text-based teaching scenarios depicting examples of behaviors in the clinical environment that may or may not represent student mistreatment. We subsequently developed six videos based on these vignettes to illustrate the tone and demeanor of the individuals in a contextual manner. We used these scenarios to trigger interactive small-group discussions. We created a PowerPoint presentation with embedded learning environment scenarios for training purposes. Since developing this program, student awareness of what constitutes mistreatment and how to report it has increased to almost 100% consistently. As part of the WE SMILE program, we offered interactive seminars and workshops during medical student orientation, at departmental faculty meetings, at joint meetings with residents and faculty, and to nursing leadership. Our training module and six videos may be used alone or in conjunction with other *MedEdPORTAL* video-based curricula to adapt to an institution's particular requirements.[17,18] Although the PowerPoint focuses on our own institutional processes, it can be easily adapted to incorporate individual schools' processes. We have provided notes in the PowerPoint indicating where users can substitute institution-specific links to appropriate sites and institution-specific contact information.

The goals of this training module are to help the learner recognize appropriate and inappropriate behaviors in the learning environment, understand what behaviors constitute mistreatment, and be able to identify the mechanisms by which these behaviors can be reported institutionally. The module can be adapted to the level of trainee and modified to accommodate differences in institutional reporting mechanisms.

Methods

Target Audience
The target audience is primarily medical professionals and trainees at various levels of clinical exposure. The module may be presented during orientation sessions to medical school and during transitions to clinical care or transitions to residency. The module may also be presented to residents, nursing staff, and attending physicians.

Venue
It is best to present this session to a large group (e.g., an entire class or a large portion of a class of medical students). Participants should be divided into small groups sitting at round tables to facilitate discussions. Groups of six to eight participants work best.

Implementation of the Module
Overview of the session: The teaching materials consist of six case-study videos (Appendices B-G) and a PowerPoint (Appendix A) containing background material on appropriate and inappropriate behaviors, mechanisms for reporting inappropriate behaviors, and text versions of the cases along with institutional responses. We have also included a document containing full written transcripts of the six case-study videos (Appendix H). A typical session runs for 90 minutes. There are various groups for which this training module may be effective: The session can be presented to an entire class of medical students, although it is best if the class is divided into smaller groups of six to eight students per group for discussion. Additional groups may be residents entering their PGY 1 year, faculty from specific medical specialties, nurses, other allied health professionals, and groups of faculty, residents, nurses, and students within a particular clerkship.

At the beginning of the session, the facilitator can present the PowerPoint to set the stage for discussions about appropriate and inappropriate behaviors in the learning environment. Specific institutional mechanisms for reporting inappropriate behaviors can be incorporated into this PowerPoint to address Educational Objective 5. This introductory PowerPoint presentation should take about 20-25 minutes. Following the presentation, the facilitators describe how they will present several vignettes, after which the learners will report whether or not they feel the situation involves student mistreatment, their reasons why or why not, and what additional information they would need to make their decision. The facilitators may choose to use any combination of text- or video-based vignettes. The videos range from 1 minute, 38 seconds, to 4 minutes, 14 seconds, in length.

Conducting the session:

1. Introduction to the topic of appropriate and inappropriate behaviors in the learning environment: The PowerPoint is designed to help facilitators introduce the topic and present the institutional philosophy and perspective on appropriate learning environments as well as mechanisms to report inappropriate behaviors. Facilitators should use this time to introduce key personnel to whom learners can report incidents including, but not limited to, Dean's Office personnel, clerkship directors, and/or Title IX coordinators, as appropriate for the institution. Embedded in the PowerPoint are six cases that may be given as text-based cases or video cases for participants to discuss in small groups. All six cases were developed based on real scenarios experienced at our institution.

2. Small-group discussion and large-group report-out:

   - When presenting to an audience of medical students, we divide an entire class of medical students into small groups of six to eight students, balanced for gender, date of college graduation, college major, our institution or other New York State universities, Ivy League or prestigious undergraduate private college, and state of residence. These small groups are maintained throughout the preclinical phase of our curriculum and are established prior to the start of the curriculum. Other institutions may divide their learners into small groups that appropriately balance and reflect their own demographics (e.g., gender, race, ethnicity, age). The small groups are seated at round tables to facilitate discussion of the cases. Following the PowerPoint presentation, the cases are presented in either text or video format. If a text-based case is used, the facilitator reads the case to the class. Alternatively, the video may be presented to the audience. The groups are then instructed to review and discuss the case. The facilitator asks the audience whether or not they thought the case represented mistreatment or whether additional information is needed. Representatives from small groups are called upon to discuss their points of view. Each case needs approximately 10 minutes of time (1-2 minutes to present the case, 3 minutes for small-group discussion, and 5 minutes to report representative small-group responses to the large group).
   - After the case is presented, participants are instructed to discuss amongst themselves the following important question sets:
     - Is this mistreatment? What are your reasons why or why not?
     - Do you need more information? If so, what additional information would you need?

     This allows for an interactive and engaging discussion among the participants. The facilitator then asks for a show-of-hands vote on whether the case is or is not mistreatment or whether additional information is needed. After representative responses have been presented from small groups, the facilitator presents the institutional response, in either text or video format.

3. Concluding remarks: The facilitator should end by asking the learners for feedback about the session. Do they feel comfortable recognizing and reporting inappropriate behaviors? Do they know the mechanisms by which to report such behaviors?

4. Time line for module:
   - Presentation of PowerPoint should take 20-25 minutes.
   - Case presentation, small-group discussion, group reporting of opinions, and facilitator-mediated discussion should take 10 minutes per case, for a total of 60 minutes.
   - Concluding remarks should take 5-10 minutes.

Content of Case Scenarios

- Case 1: The Medical Student on Rounds (Appendix B)—Educational Objective 1.
- Case 2: Requesting a Letter of Reference (Appendix C)—Educational Objectives 2 and 3.
- Case 3: The Operating Room (Appendix D)—Educational Objectives 3 and 4.
- Case 4: The Eager Medical Student (Appendix E)—Educational Objectives 1 and 3.
- Case 5: Social Media (Appendix F)—Educational Objectives 1 and 2.
- Case 6: The Nurse (Appendix G)—Educational Objective 4.

Summary of Case Scenarios

- Case 1: The Medical Student on Rounds (Appendix B)—In this scenario, the student arrives late to rounds. The resident reprimands the student in front of other students. The student returns to the resident later in the day to discuss the morning's events, at which time the resident continues to hold that it is the student's responsibility to be on time. The student subsequently meets with the clerkship director, who is aware of the situation and supports the viewpoint of the resident.
- Case 2: Requesting a Letter of Reference (Appendix C)—In this scenario, a female medical student is meeting a male surgeon for a letter of reference for her applications to plastic surgery residency programs. The surgeon has requested that they meet at a local restaurant. The meeting lasts for 90 minutes, after which the surgeon suggests a follow-up meeting. The student reports to the Dean's Office that she felt uncomfortable and does not want to go to the second meeting.
- Case 3: The Operating Room (Appendix D)—In this scenario, a long procedure is being performed by a surgeon with the assistance of two residents and a medical student. During the procedure, a major blood vessel is nicked, at which time the surgeon uses offensive language and utters a gender-insensitive remark to the medical student.
- Case 4: The Eager Medical Student (Appendix E)—In this scenario, a medical student is receiving mid-clerkship feedback from the chief resident. The student comments that there was not enough time to discuss a recent interesting case. The chief resident relays that message to the supervising resident, who subsequently asks the student to prepare a short presentation on the case for the next day.
- Case 5: Social Media (Appendix F)—In this scenario, while taking a break from studying, a student turns to Facebook to see that another student has posted disparaging remarks about her. She reports this to the clerkship director.
- Case 6: The Nurse (Appendix G)—In this scenario, a medical student for whom English is a second language is attempting to draw blood from a patient for the second time. A nurse sees this, angrily asks the student what he is doing, and tells the student that he does not speak English well.

Results

We have presented this module to our entering medical school class for the past 5 years (class size approximately 124-132 students per year) as part of an orientation week. Thus, these learners have not yet had experiences in the clinical learning environment. Here, we present summaries of the responses from these novice learners to each of the six case scenarios. This information may be helpful to other faculty who want to use these cases for training purposes as they prepare and deliver such sessions.

Summary of Participant Responses to the Cases
Case 1: The Medical Student on Rounds—Typically, there was a mixed response to this scenario. Generally, 60% of the entering medical students upheld that it was the student's responsibility to be on

time, whereas 40% felt that the tone and demeanor of the resident were abrasive and an example of public humiliation. In this case, it is helpful to solicit comments from several representative groups during the large-group report-out.

Our institutional response is that this is not a case of mistreatment as students are expected to meet all requirements expected of the profession of medicine. The student in the case continues to come in late despite having been counseled. This is irresponsible behavior. The tone and demeanor of the supervising resident must be respectful during the feedback comment.

Case 2: Requesting a Letter of Reference—This scenario received mixed responses. During most presentations of this case, about 25% of the entering students felt that it was OK to meet off-site for this meeting and did not feel that the venue or the length of the meeting was inappropriate. In contrast, about 75% felt that the meeting should be in the surgeon's office and that all of the information could be gathered in a single meeting.

Our institutional response to this scenario is that faculty should not solicit private meetings at restaurants. A better venue is an open office. Ninety minutes seems too long for a meeting to discuss a recommendation letter. The need for a follow-up meeting after the initial 90-minute meeting is unclear. Maintaining professional boundaries is expected of all professionals.

Case 3: The Operating Room—Following presentation of this case, more than 95% of students viewed it as an instance of student mistreatment and inappropriate behavior. However, about 5% felt that this behavior was appropriate in certain critical situations as long as there was a case-specific debriefing after the procedure.

Our institutional response is that this is an abuse of power. Using foul language, throwing instruments, and making gender-insensitive comments all define this case as a clear mistreatment situation.

Case 4: The Eager Medical Student—This case had mixed responses. Usually, around 75% of students thought that it was appropriate for the supervising resident to ask the student to present the case the next day. However, 25% felt that the thought-bubble voiceover indicated the resident was being punitive in asking the student to prepare the case for presentation.

Our institutional response is that asking a student to review the literature and give a presentation is within professional expectations. However, if the request is punitive in nature, if the same student is asked to do this many times (different from the other students), or if the tone and demeanor of the supervising resident are not respectful, the request can be considered mistreatment.

Case 5: Social Media—After viewing this case, 100% of the students thought this scenario was an example of cyberbullying and was inappropriate behavior.

Our institutional view is that the student posting on Facebook has used inappropriate language and has denigrated her peer and the faculty. The School of Medicine has a social media policy that prohibits disrespectful conversations regarding peers, faculty, and supervisors. This is definitely mistreatment.

Case 6: The Nurse—One hundred percent of the entering students felt that this was inappropriate behavior on the part of the nurse, who displayed a culturally insensitive attitude and was possessive of her patient.

Our institutional response is that while it may be normal for caregivers to feel connected to their patients, this does not excuse inappropriate language or denigrating comments. This is definitely mistreatment.

Changes in Participant Awareness
Since we began utilizing this training module, data derived from both the annual AAMC MSGQ survey and our own internal student surveys have shown positive trends in student awareness of our policies, what constitutes mistreatment, and the mechanisms by which students can report mistreatment incidents. Since

the inception of the WE SMILE program, according to MSGQ survey results, student awareness of our policies and what constitutes inappropriate behaviors has increased from 51% (2010) to 100% for the past 4 years (2013, 2014, 2015, and 2016).[16] As part of our standard program evaluation practices, our fourth-year students are surveyed internally prior to their participation in the annual MSGQ, and these internal survey results are consistent with MSGQ data.[16]

Discussion

This training module can be presented to individuals at the different stages of their professional development. We have presented this module to several classes of medical students, to mixed groups of residents, and at both nursing leadership meetings and departmental faculty meetings.

During the discussions of the cases, it is important to ensure that all opinions are solicited from the participants. There is value in having all the learners hear and respond to comments that their peers make following viewing or discussion of the vignettes. After the small-group discussions, the facilitator asks for a show of hands in response to the question, "Is this a case of mistreatment?" The facilitator asks, "Why or why not?" Additionally, the facilitator may ask, "Do you need more information? What type of information would be helpful?" These focused questions permit dialogues to take place among the learners from the various groups. Since some of these scenarios may elicit uncomfortable conversations, it is important that faculty facilitators be skilled in handling such conversations in a public manner to keep the session focused on the overall educational objectives.

Our primary training focus has been on medical students, but the learning environment consists of faculty, residents, nurses, and other health care providers as well. We plan to introduce these cases to mixed groups (e.g., faculty, residents, nurses, and students) in a particular specialty clerkship. The purpose of these introductory meetings will be to initiate an open dialogue on different perspectives across professions and levels of training regarding common learning environment issues that are specific to each clerkship.

To evaluate the impact of such training in greater detail, we plan to collect individual and group data using contemporaneous online surveys while the class is in progress. Qualitative data on the specific reasons why a student or group chose a response to the scenarios will be helpful in understanding their thought processes.

Limitations
The training sessions have been successful in improving the awareness of policies related to the learning environment and recognition of inappropriate behavior. However, since we asked groups to vote on the cases openly in public, we are unable to quantify the effects of such training at an individual level. In the future, polling learners individually and in groups with a survey instrument will allow more precise quantifying of their responses to the cases. Because the training is provided to early medical students, the results may not be representative of the whole medical student body as students' perception of the learning environment might evolve during their educational development. Additionally, we could present the case studies (PowerPoint and videos) to the learners after they have more experience in the clinical environment to determine how their perception of the learning environment evolves during their educational development. Finally, our case scenarios were based on incidents that have been reported at our institution and may not capture the breadth and scope that trainees could encounter. We encourage institutions to select case scenarios reflective of behavioral issues commonly encountered in their learning environment.

In summary, we created and implemented a training program for the past several years and have had great success in enhancing learner awareness of what constitutes mistreatment and how to report it. A growing number of educational resources are becoming available in video and other formats,[17-19] and institutions may combine these resources with our case studies to fit the requirements and culture of their individual situations.

AAMC

Informed Consent
All identifiable persons in this resource have granted their permission.

Ethical Approval
Reported as not applicable.

References

1. Silver HK. Medical students and medical school. *JAMA*. 1982;247(3):309-310. https://doi.org/10.1001/jama.1982.03320280029024

2. Rosenberg DA, Silver HK. Medical student abuse: an unnecessary and preventable cause of stress. *JAMA*. 1984;251(6):739-742. https://doi.org/10.1001/jama.1984.03340300031023

3. Baldwin DC Jr, Daugherty SR, Eckenfels EJ. Student perceptions of mistreatment and harassment during medical school: a survey of ten United States schools. *West J Med.* 1991;155(2):140-145.

4. Richardson DA, Becker M, Frank RR, Sokol RJ. Assessing medical students' perceptions of mistreatment in their second and third years. *Acad Med.* 1997;72(8):728-730. https://doi.org/10.1097/00001888-199708000-00022

5. Sheehan KH, Sheehan DV, White K, Leibowitz A, Baldwin DC Jr. A pilot study of medical student "abuse:" student perceptions of mistreatment and misconduct in medical school. *JAMA*. 1990;263(4):533-537. https://doi.org/10.1001/jama.1990.03440040072031

6. Kassebaum DG, Cutler ER. On the culture of student abuse in medical school. *Acad Med.* 1998;73(11):1149-1158. https://doi.org/10.1097/00001888-199811000-00011

7. 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):749-754. https://doi.org/10.1097/ACM.0000000000000204

8. Gan R, Snell L. When the learning environment is suboptimal: exploring medical students' perceptions of "mistreatment." *Acad Med.* 2014;89(4):608-617. https://doi.org/10.1097/ACM.0000000000000172

9. Oser TK, Haidet P, Lewis PR, Mauger DT, Gingrich DL, Leong SL. Frequency and negative impact of medical student mistreatment based on specialty choice: a longitudinal study. *Acad Med.* 2014;89(5):755-761. https://doi.org/10.1097/ACM.0000000000000207

10. Wright M, Hill LH. Academic incivility among health sciences faculty. *Adult Learn.* 2014;26(1):14-20. https://doi.org/10.1177/1045159514558410

11. 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):1191-1198. https://doi.org/10.1097/ACM.0b013e3182625408

12. 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):705-711. https://doi.org/10.1097/ACM.0000000000000199

13. Fnais N, Soobiah C, Chen MH, et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. *Acad Med.* 2014;89(5):817-827. https://doi.org/10.1097/ACM.0000000000000200

14. Skochelak SE, Stansfield RB, Dunham L, et al. Medical student perceptions of the learning environment at the end of the first year: a 28-medical school collaborative. *Acad Med.* 2016:91(9):1257-1262. https://doi.org/10.1097/ACM.0000000000001137

15. Anthony A, Jones A. Eradicating abusive behavior: time to adjust the educational paradigm. *Med Teach.* 2016;38(6):535-536. https://doi.org/10.3109/0142159X.2016.1150988

16. Fleit HB, Iuli RJ, Fischel JE, Lu W-H, Chandran L. A model of influences on the clinical learning environment: the case for change at one U.S. medical school. *BMC Med Educ.* 2017;17:63. https://doi.org/10.1186/s12909-017-0900-9

17. Rich A, Ackerman S, Patel C, Feldman N, Adams D, Lewis J. Creating a positive learning environment: educational film and discussion guide. *MedEdPORTAL.* 2015;11:10131. https://doi.org/10.15766/mep_2374-8265.10131

18. Mazer L, Liebert C, Bereknyei Merrell S, Lin D, Lau J. Establishing a positive clinical learning environment in the surgery core clerkship: a video-based mistreatment curriculum. *MedEdPORTAL.* 2015;11:10313. https://doi.org/10.15766/mep_2374-8265.10313

19. Reddy S, Ogden P, Arora V, et al. Is it mistreatment? Mistreatment education for medical students entering clinical training. *MedEdPORTAL.* 2013;9:9569. https://doi.org/10.15766/mep_2374-8265.9569

AAMC