Caught in the Middle: A Resident Perspective on Influences From the Learning Environment That Perpetuate Mistreatment
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Abstract
Understanding and addressing the issue of learner mistreatment is among the most pressing challenges facing academic medicine today. Despite the fact that residents have a significant influence on the clinical learning environment and may be both recipients and perpetrators of mistreatment, the resident perspective on the issue of learner mistreatment is notably sparse in the medical education literature.

In this Commentary, the authors provide a resident response to recent data showing that mistreatment is subjective and may occur on a spectrum from incident-based mistreatment to environmental-based mistreatment. They focus on specific factors from the learning environment that may increase a learner’s tendency to feel mistreated or have a suboptimal learning experience, including team cohesion, marginalization, peer-on-peer mistreatment, witnessing mistreatment, hierarchies, interdepartmental mistreatment, acculturation of uncivil behaviors, and residents themselves. This is followed by a discussion of proposed solutions to mitigate the negative impact of these influences and build safe learning environments, collaborative teams, empathic teachers, and resilient learners.

Studies have shown persistent and alarming rates of mistreatment reported by medical students,1,2 and this topic has remained a top priority for academic medicine’s institutions, leaders, teachers, and students worldwide. As collective understanding of this issue has evolved, greater emphasis has been placed on the role of the learning environment in perpetuating high rates of learner mistreatment.3,4 Most reports have focused on the experiences of medical students, with little representation of the resident perspective in the medical literature. This void is problematic because residents have a major influence on the quality of a learning environment3,5 and are uniquely positioned as both teachers and learners to propagate, mitigate, and/or experience mistreatment.

Our goal is to provide a resident perspective about data that suggest that learner mistreatment is a subjective experience, influenced by both personal and environmental factors,3,6 and that it may exist on a spectrum of incident-based mistreatment to environment-based mistreatment.7 Investigations about mistreatment have primarily focused on incident-based mistreatment meeting strict definitions (i.e., humiliation, sexual harassment), and little is known about the role of environmental factors. With the help of resident and student collaborators during our time as leaders of a multispecialty resident organization, we identified specific factors from the learning environment that may influence a learner’s tendency to feel mistreated and/or contribute to a suboptimal learning experience. In this Commentary, we provide a brief synopsis of each influence and suggest solutions to mitigate their potential to lead to mistreatment.

The Influences
Team cohesion
Clinical teaching teams are highly unique entities, often formed on an ad hoc basis and made up of ever-changing members from different departments, levels of training, and individual backgrounds. Members of highly cohesive teams may perceive a more positive learning experience even in suboptimal learning environments; conversely, poorly cohesive teams may generate a more negative learning experience and perceived mistreatment through the loss of psychological safety, respect, and/or trust.4,7 The rotational model of clinical training and constant team rearrangement may impede development of team cohesion and meaningful working relationships, which are best nurtured by time and continuity. Furthermore, outside stressors including poor work–life balance, fatigue, and heavy workloads may influence team dynamics and exacerbate dysfunctional working relationships.

Marginalized learners
Learners marginalized within teams may be at particularly high risk of psychological distress. Marginalized learners may include those who differ from team- or environment-based norms because of race, gender, sexual orientation, social views, level of extroversion, mental health challenges, subspecialty, or degree (e.g., MD versus DO). Other examples include those perceived as receiving differential treatment such as learners in difficulty, the “golden child” who excels, breastfeeding mothers, or residents operating under different duty hours restrictions. This “outsider” status may lead to negative attitudes from other team members (including faculty) or differential learning experiences, creating higher levels of perceived mistreatment for those affected. Marginalized learners who view themselves as others perceive them (i.e., different and/or unworthy) risk developing personal...
shame, a powerful emotion associated with negative coping mechanisms and outcomes.8

Peer-on-peer mistreatment

Peer-on-peer mistreatment encompasses an overt form of mistreatment that is not easily recognized or frequently reported. In the 2012 Association of American Medical Colleges Graduation Questionnaire (GQ), 6% of respondents reported mistreatment from other medical students,1 but the nature and outcomes of this type of mistreatment are not known. In our experience, power differentials, hierarchies, and efforts to stand out among peers may generate competitive teams where members degrade others in pursuit of self-driven interests. Peer mistreatment may engender significant distress because it may arise unexpectedly from team members previously viewed as confidants, partners, or supporters. The risk may be especially high for individuals in suboptimal learning environments who seek support from peers but, instead, receive the opposite.

Witnessing mistreatment

Witnessing disrespectful treatment may be as damaging as receiving it. Witnessing the mistreatment of others may diminish psychological safety within the learning environment, lessening all learners’ willingness to speak up, admit their mistakes, and engage in uncomfortable but necessary learning processes. Furthermore, learners who witness mistreatment may be inclined to keep quiet as a way of protecting their own learning experience. These avoidance behaviors may constitute a new variant of the hidden curriculum: one in which the desire is not to better fit in but, rather, to avoid “sticking out” and experiencing similar mistreatment. Medical students and interns may be especially susceptible to the effects of witnessing mistreatment given the difficulty of differentiating it from the “normal” culture of medicine.

Hierarchies

Although hierarchies serve necessary and positive functions (e.g., assigning responsibility and determining roles on teams), they may propagate mistreatment and negative learning experiences at all hierarchical levels. Individuals at the bottom of clinical hierarchies (i.e., medical students and interns) may be the most vulnerable, as they are exposed to the highest number of potential sources of mistreatment5; in the 2012 GQ, 70% of reported mistreatment originated from clinical faculty, interns/residents, and nurses.1 Learners at lower levels of hierarchies may also experience “benign neglect,” a likely prevalent but underrecognized form of mistreatment in which learners are excluded from meaningful learning experiences, given responsibilities without appropriate support or oversight, or held to unclear or changing expectations.6 Benign neglect may lead to disengagement, resulting in negative effects on learning and well-being and a perception of mistreatment.5 Furthermore, it can be equally detrimental for fully engaged learners, whose excitement and motivation may be supplanted by frustration and disappointment, as it is for disengaged learners whose efforts to “fly under the radar” and avoid uncomfortable but necessary learning opportunities may be further entrenched.

Residents in the later stages of training form the higher levels of clinical teaching hierarchies; however, they may perceive that they are taking steps backward as they struggle to assume new roles of team leader, teacher, and primary caregiver. For these residents, adopting new identities while continuing to endure the emotionally challenging experience of learning medicine may cause personal distress and significant role confusion. Lack of preparation for these roles may lead residents toward damaging self-assessments and high stress levels when they fail to meet the challenge of learning, teaching, and practicing medicine simultaneously. These reactions may be intensified further if residents perceive poor support from supervisors, are publicly mistreated in front of others, or experience “hierarchical reversal” when members at lower levels exhibit capabilities that surpass their own.

Acculturation of uncivil behaviors

The culture of medicine is marked by an inexplicably high tolerance for disrespectful treatment, with pervasive effects on the learning environment.3,10 Disrespectful behavior masquerading as “necessary” teaching methods remains common, and the belief that “you remember what was yelled at you” permeates many learning environments. Medical learners are often encouraged to adopt a “thick skin” for handling uncivil behaviors, a practice that ultimately reinforces and propagates a culture tolerant of such behavior. Knowingly subjecting medical learners to harsh working conditions that increase the likelihood of error but are accepted as “normal” (e.g., unduly long hours, sleep deprivation, and excessive workloads) is another form of systemic disrespect that may put both learners and patients at risk.8 Opponents of reform efforts fear that adopting a more sensitive approach will make their learners “soft” and unable to survive in unforgiving clinical environments. This misguided sentiment fails to recognize the need to help learners develop resilience while pushing them to the upper limits of achievement.

Interdepartmental mistreatment

Lack of civility between departments is another form of disruptive behavior within suboptimal learning environments. Studies show that specialty-based mistreatment is high among students entering both primary care and subspecialty fields11,12 and that it can generate perceptions of being denied learning opportunities, lower evaluations, and fearful approaches to self-expression.13 This “interdepartmental mistreatment” may also occur between other groups, including administrators, advanced practitioners, nurses, and learners from other institutions. Uncivil interdepartmental behavior may manifest as harsh communication, “specialty bashing,” lack of respect for others’ skills, or even direct bullying, all of which may have direct effects on learners caught in the crossfire. Furthermore, learners attempting to avoid negative outcomes by “fitting in” on their teams may buy into interdepartmental stereotypes and mimic the behavior of the team leader, further propagating the culture of disrespect.

Residents themselves

The 2012 GQ1 showed that residents were a primary source of medical student mistreatment. In many clinical learning environments, students spend more time with residents than with faculty, leaving residents with a tremendous responsibility for students’ learning experiences. Assuming this responsibility may represent a serious challenge for residents who are ill prepared to provide supervision, are struggling with role confusion, are burned out or depressed,
are struggling at home, or have an unresolved history of being mistreated themselves. They may direct the tension, inadequacy, and frustration generated by this struggle toward others on the clinical team, especially those at lower levels of the hierarchy and in other departments, and in a manner that may lead to direct or perceived mistreatment (e.g., humiliation, benign neglect, annoyance). Thus, many of the same influences that may increase a resident’s tendency to feel mistreated may in turn increase his or her tendency to mistreat others, suggesting a downstream effect.

Potential Solutions

Residents’ unique and influential position as teachers and learners should also be seen as an opportunity to resist, and even eradicate, the flow of mistreatment. Programs and institutions are called to develop policies that (1) assist residents in their efforts to exert positive influences on the learning environment and (2) protect learners at all levels from the damaging effects of learner mistreatment. This might occur through initiatives that build resilient, prepared residents who are able to successfully adopt multiple roles and engender diverse and highly functioning teams, all within enhanced institutional cultures.

Building individual resilience

Helping learners and teachers develop resilience in the face of the adversity that accompanies learning medicine should be a top priority for teaching institutions. Resilience training should incorporate methods with validity evidence and take into account the physical, emotional, and social stressors for which many learners are unprepared. Training should occur in a longitudinal fashion, starting as early as the undergraduate years, and be built on a foundation of self-awareness, self-monitoring, and self-regulation.

Building effective teachers

Enhanced resident-as-teacher training is a critical element of the solution to learner mistreatment and suboptimal learning environments, and should be offered as a routine part of residency training. Teaching residents to provide effective feedback, recognize and adjust to emotional responses in other learners, and set and adhere to clear expectations will be important to successfully guide all learners through learning processes and away from damaging self-assessments. Leadership development should also be offered, including training on conflict resolution, cultural sensitivity, and effective team management.

Building prepared learners

Transitions across the medical education continuum can be highly stressful experiences that generate role confusion and uncertainty, especially if learners are ill prepared for the next set of challenges. Faculty and mentors at all levels should address the emotional, mental, and physical challenges learners will face with each transition to instill basic coping mechanisms for when (not if) these challenges occur. Programs might also adopt formal preparatory training programs, as they have been shown to lead to supportive learning environments, more clearly defined roles, and less stress at transitions.

Building better teams

Institutions and programs should routinely assess for marginalized learners and peer-on-peer mistreatment. Sufficient protections should be ensured for those at high risk of marginalization, with close monitoring for emotional difficulty. Programs should leverage the power of diversity, explore potential biases, and openly discuss power differentials to build inclusive and dynamic teams where all members feel valued. Building teams more purposefully and with decreased turnover may also help achieve this goal, as seen with longitudinal clinical experiences. Compared with the rotational model of clinical learning, longitudinal experiences are associated with safer learning environments, more supportive relationships with faculty, more trusting relationships with colleagues, less exposure to the hidden curriculum, and more satisfying learning experiences.

Building a better culture

Reforming the culture of disrespect in medical education requires a sweeping transformation accomplished only through a common sense of purpose among all members of the academic medicine community. Focusing on eradication of blatant mistreatment is a first step toward meaningful cultural change; however, failure to recognize the role of everyday influences such as team dynamics, hierarchies, and insidious disrespect on the learning environment will hamper efforts to bring about lasting change. Recognition of these influences should occur alongside development of institutional policies that make learners feel safe within the learning environment and valued within the academic medicine enterprise. Ultimately, a foundation of respect for human life should be the primary block on which a culture of civility is built, one that will aid in the development of collaborative teams, empathic teachers, and resilient learners who rise to the challenges of teaching, learning, and leading in medicine.

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