AUSTRALIAN
MEDICAL STUDENTS'
ASSOCIATION

Submission to Senate Inquiry

Medical Complaints Process in Australia

Introduction

The Australian Medical Students' Association (AMSA) is the peak representative body of the 17,000 medical students around Australia. AMSA meets with elected representatives from every medical school three times a year to develop a national perspective on relevant issues.

AMSA believes that all people have the right to be treated with respect in their place of education and work, and a right to education and working conditions that promote good mental and physical health. Accordingly, AMSA calls for the removal of educational practices that utilise intimidation and bullying, and for education on supportive teaching practices for those teaching and supervising students. AMSA also calls for a safe environment for reporting regarding bullying and harassment in the medical workplace.

The role of bullying and harassment in medical education

The Australian Medical Association (AMA) defines bullying as, "*a pattern of unreasonable and inappropriate behaviour towards others, although it may occur as a single event. Such behaviour intimidates, offends, degrades, insults or humiliates an employee [and] can include psychological, social, and physical bullying*". **1**

The hierarchical structure of medical education, while performing a positive role in other aspects of training and patient safety, lends itself to a culture in which bullying can occur and remain unchallenged. Even when their dysfunctional nature is recognised, intimidation and harassment are seen as functional educational tools. **2,3**

In many cases, bullying and harassment experienced by doctors and students is perpetrated by other doctors in a 'pecking order' of seniority, although nurses and midwives can also be sources of negative behaviour, particularly towards junior doctors. **4**

The structure of medical teaching combined with the predisposition towards 'grilling' as a pedagogical tool contributes to the phenomenon of 'teaching by humiliation' in medical teaching spaces. Within clinical teaching, there is a strong adherence to the Socratic method of teaching, which is the act of asking questions to students, usually in front of patients or peers. In the US this is referred to by the slang term 'pimping', whereas in Australia and the UK, it is known more commonly as 'grilling'. In the 1989 article "The art of pimping", **5** it is defined as *"whenever a [consultant] poses a series of very difficult questions to an intern or student*", and suggests that questions "*should come in rapid succession and be essentially unanswerable*". Students divided pimping into 'good' and 'malignant' categories, roughly comparable to the Australian 'testing' and 'grilling'. 'Good pimping' or testing included questioning that enhanced the learning process or encouraged students to be proactive about their learning. 'Malignant pimping' or grilling employed techniques designed to humiliate the learner. These included "guess what I'm thinking" questions or obscure questions unsuited to the learner's level of training. **6** There are four significant results of 'grilling' or 'pimping' - "*establishing a medical staff pecking order, suppressing any honest and spontaneous intellectual question or pursuit, creating a hostile atmosphere, and perpetuating the dehumanisation for which medical education has been criticised*". **6**

The prevalence of bullying and harassment in medical education

The practice of teaching by humiliation is known to be widespread. A 2015 study published in the Medical Journal of Australia (MJA) showed that 74.0% of medical students had experienced teaching by humiliation and 83.6% of students had witnessed it. **7** In the medical workforce, bullying and mistreatment exists beyond teaching by humiliation. Harassment and bullying can also include derogatory remarks, inappropriate humour, ignoring students and setting impossible tasks or deadlines. It can also include verbal belittlement and humiliation, threats to reputation or academic success, and harassment or discrimination on the basis of gender, sexual orientation, race, religion or disability.

Existing literature suggests that up to 50% of students have come to believe that mistreatment is necessary and beneficial for learning,**7** despite teaching by humiliation being a negative experience for students. Although research has shown that medical students are resilient when it comes to witnessing traumatic clinical events,**8** medical student mistreatment has been associated with serious effects on medical students' emotional well-being and attitudes, potentially eroding values such as professionalism that the medical school curriculum attempts to teach them.**9**

Specifically, mistreatment affects mental health, with some students exhibiting symptoms of post traumatic stress, and can result in low career satisfaction, increased levels of cynicism about medicine, lack of confidence in skills, depression and anxiety in affected medical students. Verbal mistreatment affects students' confidence in their clinical abilities and their ability to succeed in training. In Australia, it has been found that 30% of students who had been mistreated had considered dropping out of medicine, or wished they had not chosen medicine as a career.**10,11**

Mental health in the medical profession

A 2013 *beyondblue* survey **12** of 14,000 Australian doctors and medical students highlighted the prevalence of mental illness in the medical profession. Both medical students and doctors were found to have significantly higher levels of psychological distress than the wider population. Additionally, almost a quarter of doctors and a fifth of medical students reported thoughts of suicide over the preceding 12 months. Despite the seriousness of this problem, many identified a barriers to seeking treatment. The stigma attached to mental illness was commonly identified by respondents, with a full 40% of both medical students and doctors believing that their peers with a history of mental health disorders were perceived as less competent than other doctors.

While this research did not explore the link between bullying and harassment of medical students and mental health, international studies have. **13, 14, 15** Bullying and harassment should be viewed in light of the seriousness of the mental health outcomes of doctors and students.

Impact of bullying and harassment on patient safety

Patients may also be put at risk by bullying in the medical workplace. Given the potentially high degree of negative impact that mistreatment can have on students, being a victim of mistreatment or observing unprofessional conduct from superiors

may contribute to the decline in empathy over time that has been documented in medical students and resident physicians.**16-21**

Bullying and harassment may also compromise patients by putting them at risk of medical errors. A report by the Joint Commission that accredits health care organisations in the United States studied adverse events over a 10-year period and discovered that communication failure was the number-one cause for medication errors, delays in treatment, and surgeries at the wrong site, and was the second leading cause of operative mishaps, postoperative events, and fatal falls. **22** It has been quoted in Academic Medicine that "'*a substantial barrier to progress in patient safety is a dysfunctional culture rooted in widespread disrespect*" as "*it inhibits collegiality and co-operation essential to teamwork, cuts off communication, undermines morale, and inhibits compliance with and implementation of new practices*". **23,24**

Improving medical education

To improve medical education and reduce instances of bullying and harassment in the medical workplace, a paradigm shift is required in medical education. In contrast to teaching by humiliation, modern interpretations of the Socratic method (utilising critical thinking) integrate three major components: 1) working collaboratively in groups, 2) exploring interpretive questions which lack a specific answer but activate prior knowledge, and 3) reflecting on the discussion.

A suggested change to reflect the current practice of the Socratic method of medical teaching could be an interpretive question posed by either the learner or the educator to a group of learners, followed by a discussion seeking to activate prior knowledge (for example, requests for a differential diagnosis, the application of various tests and procedures to help confirm the diagnosis, and therapeutic options given evidence based studies and patient preferences for care), identify and explore misconceptions learners may have, and gain insight into the problem.
Group reflection or debriefing about the dialogue that examines both the content and the process of discussion would be beneficial to aid in the development of a safe and supportive learning community.**6**

Teaching and education on building resilience could assist students to improve their assertiveness and empower them to report such issues. This can be coupled with the implementation of a supportive bystander model, wherein medical students support their fellow students by responding when bullying occurs to their peers, supporting students who have been bullied, and proactively preventing bullying behaviours in their medical school. **25**

The role of specialist medical colleges and universities

Medical Colleges

Medical specialisations, for example General Practice, paediatrics and surgery, each have separate specialist medical colleges. These colleges act as the education provider for doctors during vocational specialty training (after completion of a medical degree).

Since early 2015, there has been particular media scrutiny of the Royal Australasian College of Surgeons (RACS), who have responded with a plan for addressing bullying and harassment within the College. However, this same public pressure has not been

applied to all Colleges. As such, not all areas of the medical profession have explored and addressed bullying and harassment with the same vigour. In order for wholesale reform of the culture of medicine to occur, Colleges will need to address bullying and harassment in the same manner as RACS.

Universities

There have been a range of responses from universities following the media attention towards bullying and harassment in the medical profession and medical education. Some students report they have seen no significant response from their university. While it is important to acknowledge that significant work may have been undertaken 'behind the scenes' without the knowledge of students, it is AMSA's position that an appropriate response from a university cannot be undertaken without establishing the rate of bullying and harassment within their medical school, and thoroughly reviewing their reporting structures to identify barriers.

As a majority of medical education involves hospital placements, there is also confusion amongst students as to whether they are able to report instances of bullying to their medical school or alternately to their hospital. The result is often that no reporting of an incident occurs.

There is a belief amongst medical students that where a response from a university has not been forthcoming, it may be due to a reluctance of that university to take responsibility for instances of bullying and harassment experienced by students in the course of their degree. It is perceived that universities view acknowledging and discussing the high rates of bullying and harassment within medical education as an acknowledgement of their responsibility to act to prevent future occurrences.

Barriers to reporting bullying and harassment

In addition to improving medical education itself, resolving the culture of bullying and harassment in medicine requires removal of barriers to reporting. Recognised barriers to reporting include the belief there will be no benefit to challenging the abuse, fear of receiving negative feedback or poor marks in assessments from the perpetrator, and fear of gaining a bad reputation which could affect the victim's long term career prospects. Students have also reported a sense of inferiority and disempowerment and described social etiquette against undermining a senior doctors' authority. Other reasons for not reporting included lacking the authority as a student, the belief that the abuse was the student's fault, and being told not to report by their confidantes.

Systemic problems

- Reporting processes are often unclear to students, as they differ from hospital to hospital and are rarely publicised to students at the time of clinical placement. Medical students rotate through different hospitals during the course of their degree, without a centralised resource instructing them how to report bullying and harassment
- A problem specific to medical students is that their reporting systems fall under two umbrellas - the university and the hospital. The university reporting system may focus on actions by their staff or incidents that occur on campus. However, as much of the bullying and harassment occurs in the hospital setting, medical students are not necessarily covered by university policy.

Similarly, as medical students are not paid staff of the hospital not volunteers, they can 'fall between the cracks' of hospital policy
- Where reporting processes are available, they are often not considered truly anonymous and may place the reporter in a compromised position where they may be disbelieved or bullied further as a result of reporting
- Some of the doctors who provide reports of student performance in the hospital are also faculty of the students' medical school. They therefore may be closely linked to the perpetrator, either professionally or socially. There may also be instances where the person who handles such a report within the faculty is also the person responsible for the abuse

Cultural problems

- The hierarchy of the hospital environment creates barriers to the reporting of abuse. As the perpetrator is often a more senior doctor, they can have direct control over the student's academic future. Therefore, there is a motivation not to make a complaint for fear of gaining negative feedback or poor marks in assessments from the perpetrator. As securing jobs relies on good references, there is also a fear that gaining a bad reputation for reporting in one hospital can affect the victim's long term career prospects
- The hierarchical culture of medicine also means there is a social etiquette against undermining the authority of a senior doctor
- Similarly, a medical student, junior doctor or nurse may feel they lack the authority to report abuse

Beliefs

- Studies of abuse in medical school demonstrate a sense that victims believe the abuse is not serious enough to report, that they are being 'too sensitive' or that they deserve the abuse as a part of their medical education
- There is a pervasive sense of disempowerment. As a result of this, there can be a belief that there will be no benefit to challenging the abuse
- This is bolstered by peers, who may state that the abuse was to be expected as part of medical education or wasn't severe in nature, and advise the victim not to report the incident/s
- There is the fear of being disbelieved or humiliated if peers learned of the occurrence, and there is a lack of trust in those who are in positions of authority

Recommendations

AMSA believes

1. Students have the right to professionalism in education, including teaching free from bullying, fear and anxiety
2. Teaching by humiliation and bullying in medicine have a significant negative impact on student and doctor wellbeing, patient care, and the effectiveness of hospital teams
3. Challenging this culture will require all Colleges, employers and medical deans to take responsibility for bullying and harassment directed towards, or committed by, their members, employees and students respectively
4. Individuals at all levels in health care institutions need to take action toward creating a culture of respect and to provide them with the evidence they need to support improvements in the cultures of their institutions

AMSA recommends

Hospitals and health networks to:

1. Ensure that effective reporting structures are made available to medical students without fear of reprisal, and that these reporting structures are communicated to students by those hospitals in their formal orientation process
2. Ensure that repercussions for perpetrating bullying are present for all hospital staff, including doctors, nurses and allied health staff
3. Educate all medical staff on effective and fair teaching practices
4. All hospital inductions to include teaching on what constitutes bullying and harassment, including incidents that may be perceived as inconsequential or lighthearted
5. Inclusion of medical students in all policies relating to bullying and harassment

Medical schools to:

1. Establish the rate of bullying and harassment experienced by their students, and the students' perceived barriers to reporting
2. Provide accessible, clear and confidential pathways for reporting of bullying, and actively minimise recognised barriers to reporting
3. Provide education to students and educators on acceptable teaching as well as what constitutes bullying
4. Provide education to students on how to respond themselves when experiencing harassment or as a supportive bystander
5. Provide opportunity for and encourage feedback from students on teaching and supervision during clinical rotations
6. Work with students to foster effective, supportive teaching environments, and seek regular student feedback on the success of this work

The Australian Medical Council to:

1. Specifically assess the professionalism and respectful behaviour of teachers and clinical supervisors when assessing and accrediting primary medical programs, and encourage Medical Societies to include the same in their report to the AMC
2. Require specialist medical colleges to have education programs in place regarding appropriate behaviour in clinical teaching and professionalism (including respectful behaviour to colleagues)

3. Require, as part of accreditation, specialty medical colleges to develop publicly available plans for address instances of bullying and harassment and preventing further instances

The Australian Medical Specialist Colleges to:

1. Rigorously assess the occurrence of bullying and harassment within their College, and develop and implement a publicly available plan on how they will address any such instances and prevent further instances
2. Incentivise educational opportunities and courses that improve teaching skills as avenues of gaining Continual Professional Development (CPD) points
3. Provide the opportunity for medical students to provide appropriate, anonymous feedback to the college on the performance of the trainee or Fellow as a teacher in an effort to provide robust multi-source feedback

AHPRA and the MBA to:

1. In partnership with the Australian Medical Council, review the standards for specialist education and training and make publicly available a report of the changes being made to support trainee well being
2. In investigating notifications and complaints regarding bullying and harassment, taking into consideration the risk that bullying behaviour poses to both other doctors and to patients
3. To make publicly available details of AHPRA's ongoing work to improve complaint management processes for both notifiers and subjects of notification

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