9.2.4 Disputes between Medical Supervisors & Trainees

The relationship between medical students, resident physicians or fellows, and their supervisors is a major determinant of the quality of medical education. When conflicts arise, it is essential to ensure that disputes are resolved fairly.

Retaliatory or punitive actions against those who raise complaints are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee.

Physicians who are involved in training or supervising medical students, residents, and fellows should ensure that institutional policies and procedures are in place to:

(a) Protect complainants' confidentiality whenever possible, so long as protecting confidentiality does not hinder the subject's ability to respond to the complaint.

(b) Carefully monitor employment and evaluation files to prevent possible tampering.

(c) Permit resident physicians and fellows to access to their employment files and copy the contents, within the provisions of applicable law.

(d) Support medical students, residents, and fellows in fulfilling their responsibility to:

(i) withdraw from care ordered by a supervisor when the trainee believes the order reflects serious errors in clinical or ethical judgment, or physician impairment, that could pose a risk of imminent harm to the patient or others, provided withdrawing does not itself threaten the patient's immediate welfare;

(ii) communicate concerns to the physician issuing the orders and, if necessary, to the persons or institutional programs responsible for mediating such disputes, which may involve third parties.

AMA Principles of Medical Ethics: II, III, VII

Background report(s):

CEJA Report 3-A-16 Modernized *Code of Medical Ethics*

CEJA Report 1-I-93 Disputes between medical supervisors and trainees

9.2.4 Disputes between Medical Supervisors & Trainees

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AMA Principles of Medical Ethics: II, III, VII

CEJA Report 1 – I-93
Disputes Between Medical Supervisors and Trainees

INTRODUCTION

The relationship between medical students, resident physicians, and their supervisors is a major factor determining the quality of medical education. Due process for fair resolution of disputes between medical students, resident physicians, and supervising physicians is essential for effective medical education.

In this report, the Council discusses two distinct issues. Part I discusses ways to improve existing mechanisms for handling disputes between medical supervisors and trainees through grievance and disciplinary committee proceedings. Part II examines the separate topic of disputes that cannot wait for resolution through traditional committee procedures. Disputes requiring immediate resolution may occur in those rare instances in which medical students, resident physicians, or other staff witness serious errors in clinical or ethical judgement, or physician impairment, when the error or impairment poses a serious threat to the patient's immediate welfare.

PART I: IMPROVING EXISTING DISPUTE RESOLUTION MECHANISMS

SOURCES OF CONFLICT BETWEEN MEDICAL SUPERVISORS AND TRAINEES

Because there have been few published studies in this area, the prevalence of conflicts between medical supervisors and trainees is difficult to determine. To date, quantitative data on conflicts between medical students and their supervisors come primarily from three studies.[1-3] All three involve retrospective surveys in which students were asked to indicate the frequency with which they had suffered or witnessed various kinds of abuse and misconduct. Two of these studies, both published in 1990, surveyed students at individual medical schools. One study surveyed 75 third year medical students;[1] the other surveyed 431 students of all classes.[2] The third study of medical students' perception of abuse, published in 1991, surveyed 581 senior medical students at ten medical schools across the country.[3] Though the authors of these studies state that they provide data only on student perceptions rather than objectively verifiable instances of abuse and misconduct, the significance of these perceptions should not be downplayed. Perceptions of abuse and misconduct may be the only guides available for identifying the kinds of behaviors that trainees find objectionable and that contribute to conflicts with their supervisors.

For resident physicians, data on conflicts with supervisors come from a 1991 study of 1480 residents, currently being prepared for publication. This study, Which focuses on the Internship year, expands on some of the studies of medical students described above.[4]

Because of their limited scope, these studies may not represent a wholly accurate picture of the relationship between medical students, resident physicians, and their supervisors. In addition, it is difficult to know how much perceived abuse is attributable to problems or attitudes specific to the medical profession, and how much to patterns of abuse and mistreatment prevalent throughout society. The concerns voiced by students and resident physicians are not unique to the medical profession. Some of the same concerns, especially those related to sexual harassment and gender discrimination, have arisen in other professions as well, including business and law.[5] However, these questions aside, the data presently available does indicate that trainees' perception of misconduct and mistreatment by their supervisors is an important concern for the medical profession to address.

The evidence in these studies suggests that abuse and mistreatment of all kinds comes from a variety of sources, including attending physicians, resident physicians, nurses, medical students and patients. The prevailing trend, as might be expected, is that the majority of perceived abuse suffered by an individual comes from those with greater authority rather than less.

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Abuse and Mistreatment

The studies described above document high levels of perceived verbal, academic, and physical abuse and mistreatment suffered by medical trainees, often (but not always) from supervising physicians.[1-4] In the ten-school survey of 581 senior medical school students, 81.2% - 86.7% reported having been the targets of verbal abuse, humiliation, and belittlement, and 26.4% reported having been threatened with physical harm.[3] In addition, 36.7% reported being assigned tasks for punishment, 34.8% reported being threatened with unfair grades, and 53.5% reported someone else taking credit for one's work.[3] In the single-school survey of 75 students, 44% reported being placed at unnecessary medical risk without adequate precautions,[1] and 47% reported experiencing other forms of threatening or punishing behavior from supervisors, including the assignment of tasks for punishment rather than educational purposes, threatening students with an unjustifiably bad grade, and taking credit for work the student had done.[1] The medical students identified a number of sources of this mistreatment, including clinical faculty, resident physicians and interns, nurses and other hospital staff, and other medical students.[1]

The single-school study of 431 students found that with increasing years at medical school, larger proportions of students reported having experienced abuse, with the highest incidence of abuse occuring in the junior year, when students first become involved in clinical rounds.[2] This study also documented the effect of abuse on students; 49.6% said that the most serious episode of abuse affected them adversely for a month or more, and 16.2% said that it would "always affect them."[2] In the study of 75 students, 67% felt that mistreatment had interfered with their emotional health, and 40% reported negative effects on their physical health.[1]

There have been reports of similar abuse and mistreatment suffered by resident physicians. In the survey of 1480 residents, 40% reported being assigned work or rotation responsibilities for punishment rather than for educational purposes; 49.5% reported that other persons had taken credit for their work; and 87.6% reported incidents of verbal harassment, in which they had been humiliated or belittled. Sources of mistreatment included attending faculty, resident physicians at a lower level, nurses and medical students.[4]

Sexual Harassment

Sexual harassment has also been reported by students and resident physicians.[1-9] In the single - school study of 75 medical students, 81% reported having been subjected to sexist slurs, most frequently by clinical faculty and resident physicians or interns, and 55% reported having been the object of sexual advances.[1] In the ten-school survey, 55% of student respondents reported experiencing sexual harassment.[3] In the survey of 1480 resident physicians, sexual harassment was reported by 32% of women respondents and 9.6% of men respondents.[4] Similar results were reported in a study of an internal medicine training program, in which 73% of women and 11% of men who responded reported that they had been sexually harassed at least once during their training, with about half of the reported incidents occuring in medical school and half during residency.[8] In addition, in a recent survey of over 2000 women physicians, of the 74.8% of respondents who reported having experienced sexual harassment, 79% experienced it in medical school and 64.2% in residency training.[9]

Gender Discrimination

In a recent report, the Council examined gender discrimination, including sexual harassment, in some detail.[7] Data from the studies described above, as well as those summarized in the Council's longer report, document the extent of this problem. Nearly one-third (29%) of the female medical students surveyed in the single-school study of 75 students felt that they had been denied opportunities in their training because

they were women.[1] In the ten-school survey, 24% of men and 46.3% of women felt that members of the opposite sex were given preferential treatment on the basis of their gender.[3] In addition, the survey of 1480 resident physicians showed that attending physicians on average spend slightly more time working with their male residents than they do with their female residents.[4] As the Council has discussed in its longer report, lack of mentor ship opportunities and exclusion from peer networks may also have a discriminatory impact on women.[7]

Racial Discrimination

Evidence also exists of discrimination on the basis of race or ethnicity. In the study of 75 medical students, 50% of respondents giving their race as non-white or Hispanic reported experiencing racial or ethnic slurs, either from classmates (50%), clinical faculty (33%), or resident physicians and interns (25%).[1] In the ten-school survey, 19.7% of all respondents reported some form of racial harassment.[3] The survey of 1480 resident physicians revealed that just over 20% reported some racial or ethnic discrimination coming from patients (15%), attending faculty (11%), nurses (11%), residents at a higher level (10%), residents at a lower level (7%), and medical students (4%). This reported discrimination included racial and ethnic slurs, favoritism, malicious gossip, denial of learning opportunities, poor evaluations, and racist teaching materials.[4]

Perceived Incompetency, Impairment, and Unethical Conduct

Conflict between resident physicians and attending physicians concerning patient care decisions are relatively common.[10,13] Most of these conflicts reflect reasonable differences of opinion over technical decisions regarding care, such as the relative value of one procedure or treatment over another, or over the physician's ethical responsibilities to the patient. Occasionally, however, complaints may arise as a result of care that, by consistently falling short of accepted standards of medical practice, is truly incompetent.

Conflict may also arise when trainees observe colleagues, or supervisors who are impaired or who behave unethically. For instance, 30-40% or medical students in the single-school survey of 75 students reported witnessing behavior that they believed to be unethical among other students, resident physicians and interns, and attending physicians.[1]

MECHANISMS FOR ADDRESSING CONFLICT BETWEEN MEDICAL SUPERVISORS AND TRAINEES

The means by which medical students, interns, and resident physicians resolve conflicts with attending physicians or other medical supervisors have not been well addressed in the literature. Though many training institutions have formal grievance procedures for addressing complaints from medical students and resident physicians, too often these grievance procedures are underutilized.

Existing Reporting and Grievance Procedures

The need for institutions to establish formal mechanisms for handling complaints of incompetency, impairment, and unethical conduct -including the abuse and mistreatment of medical students, resident physicians, and other staff - has been addressed by the Council in its report, "Reporting Impaired, Incompetent or Unethical Colleagues."[14] In that report, the Council recognized an ethical obligation for physicians to report impaired, incompetent, and unethical colleagues and identified appropriate authorities to whom reports should be made. Impaired colleagues should be reported to an in-house or external impaired physician program; appropriate supervisors such as the chief resident, chief of staff, or chief of the appropriate clinical service; or, if necessary, to the state licensing board. Incompetence should be reported to the appropriate clinical authority who would be empowered to assess the potential impact on

patient welfare and to facilitate remedial action. In some cases, such as when continued behavior is injurious to patients, reports should be made to the state licensing board. Unethical conduct should be reported to the appropriate clinical authority when it threatens patient care or welfare; to the state licensing board when it violates licensing provisions; to appropriate law enforcement authorities when it violates the law; and to the local or state medical society when it does not fall into any of the other categories, or when it has not been sufficiently addressed by these other authorities.[14] Medical students may also use these avenues for reporting and, in cases involving abuse directed towards themselves or other students, may report their concerns to the dean of students at their school, as well.

There are a number of sources that medical training institutions may consult when establishing formal grievance and disciplinary procedures. Procedures established by the Accreditation Council for Graduate Medical Education (ACGME) for dealing with complaints against residency programs outline the role of program directors, institutional graduate medical education committees, and residency review committees.[15] The ACGME identifies the residency review committee (RRC) as the primary body for handling grievances related to non-compliance of tile residency z program with expected standards, but states that the RRC "will not adjudicate individual disputes concerning due process."[15]

The AMA has promulgated guidelines for the resolution of disputes between individuals through its Guidelines for Establishing Sexual Harrassment Prevention and Grievance Procedures[16] and through its Guidebook for Medical Society Grievance Committees and Disciplinary Committees.[17] These documents provide useful models for establishing mecthanisms for handling complaints of professional misconduct. They include sections on substantive standards of misconduct, procedural guidelines for grievance and disciplinary committees, guidelines for screening and reviewing complaints, the role of mediation in dispute resolution, and the requirements of confidentiality and proper record keeping.

Reluctance to Report Complaints

Despite the existence of procedures for handling complaints, evidence suggests that a great deal of perceived abuse and mistreatment goes unreported and unaddressed. In the single-school survey of 75 medical students, only 12 students (16%) who had complaints reported their concerns to authorities.[1]

There are a number of reasons why traditional avenues for dispute resolution may be underutilized. Often, disputes may be resolved informally without the need for further proceedings, or the observer of the misconduct may feel that the event is not serious enough to warrant a formal complaint. Alternatively, the dispute may concern patient care issues or ethical responsibilities over which reasonable people may disagree, and so no complaint is necessary.

However, there is also evidence that fear of professional retaliation is a significant factor inhibiting the voicing of complaints even when the complaints are serious.[1,18] Medical students and resident physicians are particularly vulnerable to professional retaliation because they are dependent on their supervisors for the assignment of patient care and other duties, letters of recommendation, and promotion to the next professional level.

In the following section, strategies for reducing the fear of professional retaliation are discussed.

STRATEGIES FOR REDUCING FEAR OF RETALIATION

One method for reducing fears of professional retaliation is to provide adequate confidentiality protection for complainants.[14] As a general rule, all information received by grievance or disciplinary committees and the content of all committee meetings, deliberations, or discussions must not be disclosed or used in any manner outside of the committee setting. In addition, medical trainees and other staff need to know

that a request for confidentiality when filing a complaint will be honored to the greatest extent possible. If the subject of a complaint does not need to know who filed the complaint in order to respond to the charges, then the identity of the complainant should remain confidential. However, the desire for confidentiality does not override the rights of the subject to confront or respond to any testimony or evidence used against him or her. When necessary to protect the rights of the subject, the complainant should be notified that further proceedings may not be possible if the complainant is unwilling to have his or her name disclosed.[16\]

Of course, these protections will not be effective in encouraging reports of misconduct if the protections are not well publicized. Information about grievance and disciplinary procedures should be distributed to all medical staff, including trainees, at the beginning of their employment or assumption of duties, as well as posted in staff lounges and other areas of heavy traffic.

There must also be methods for preventing retaliation against trainees and other staff who report misconduct. Some punitive actions against complainants, such as abuse, harassment, or assignment of non-educational tasks, may be addressed by filing a complaint with the appropriate grievance committee. A disciplinary committee can go far in discouraging these kinds of punitive actions by establishing appropriate sanctions for those who abuse or mistreat others.

Other retaliatory tactics are harder to guard against. For instance, there have been anecdotal reports of resident physicians whose employment records and evaluations were altered after they filed a complaint.[18] Clearly, employment and evaluation files must be protected from inappropriate alteration by any party. Access to employment or evaluation files therefore should be monitored carefully to ensure that they are protected from tampering. For Instance, evaluations that are part of a student or resident's file should not be removed if the evaluator's opinion later changes; rather, if the evaluating physician wishes to amend his or her previous statement in light of recent developments, a separate evaluation updating the first may be added to the trainee's file. In addition, as the Council on Medical Education has stated, resident physicians should be provided with a written copy of their evaluations, permitted access to their employment files, and given the right to copy the contents of those files, within the provisions of applicable federal or state laws.[19]

There should also be some provision for resident physicians, students, and other staff to appeal negative performance evaluations that they believe to be unfair or punitive. The institution's grievance committee may fulfill this function. In screening complaints of unfair evaluations, the committee may take into account any previous conflicts between the trainee and the supervisor writing the evaluation, as well as opinions on the trainee's performance from other observers. Given the subjectivity in evaluating trainee performance, it may be difficult to distinguish unfairly negative evaluations from justifiably negative ones. However, the grievance committee will normally be in the best position to weigh the evidence on both sides and determine whether there are grounds to suspect punitive or other inappropriate motivations on the part of the evaluator. If the grievance committee finds evidence of prejudice that may have resulted in an unfair evaluation, a statement to this effect should be entered into the trainee's record, and the committee may consider referring the case to the disciplinary committee. In addition, a second evaluation of the trainee may be written by other supervising physicians who are familiar with the quality of the trainee's work.

An additional aid to consider in protecting the confidentiality of complainants and preventing possible professional retaliation against complainants is the appointment of a third-party intermediary or ombudsperson who would be largely outside of the established hospital staff hierarchy. For disputes involving students, the dean of students at the medical school could serve as an ombudsperson. Trainees and other staff who might feel uncomfortable challenging an attending or supervising physician's conduct directly could report their concerns to the ombudsperson, who could in turn convey them to the chief of

medical service, appropriate grievance committee member, or other institutional authority. The ombudsperson could then stay involved in the case as necessary, and could play a useful role as an objective observer or witness should a dispute or complaint result in formal grievance proceedings.

In addition, an ombudsperson may also play a useful role in disputes between trainees and supervisors that cannot wait for resolution through traditional channels. In Part II, strategies for handling disputes requiring immediate resolution, including the role of the ombudsperson or other third-party mediator, are discussed.

PART II: STRATEGIES FOR IMMEDIATE DISPUTE RESOLUTION

While most complaints of physician impairment, incompetence, or unethical conduct may be handled satisfactorily through formal grievance and disciplinary committees, as discussed above, these formal mechanisms may be too unwieldy to handle effectively disputes that must be resolved quickly.

In general, a dispute requires immediate resolution whenever it involves conduct that threatens the patient with imminent harm. Thus, disputes requiring immediate resolution may occur as a result of witnessing serious errors in clinical or ethical judgment, or physician impairment, when the error or impairment threatens the patient's immediate welfare. For example, a trainee could witness a supervising physician make an in- appropriate decision to consider a patient whose heart has stopped a no-code patient, when ethically the patient should be viewed as one to receive CPR.

It is important to note that most disputes between trainees and their supervisors do not fall into this category. For instance, most conflicts between resident physicians and their supervisors over the clinical management of a patient do not involve serious errors in technical or ethical judgment, but rather stem from reasonable differences of opinion about the patient's diagnosis or preferred therapeutic option. These commonplace differences of opinion are part of every physician's experience and usually resolve themselves in the course of treating the patient, as more complete information becomes available on which to base treatment decisions.

In addition, most disputes that do go beyond reasonable differences of opinion still do not require immediate resolution, but may be handled through traditional grievance and disciplinary committee procedures. Only when there is a threat of imminent harm to the patient should the established grievance and disciplinary committee procedures be bypassed in favor of immediate dispute resolution.

When a dispute does arise that involves imminent harm to the patient, the conflict must be resolved with great alacrity. Medical students, resident physicians, and other staff should refuse to participate in patient care ordered by their supervisors when it is clear that their supervisors, orders would harm the patient. The student, resident, or staff member should communicate his or her concerns to the physician issuing the treatment orders. Discussion of the problem and negotiation between conflicting parties may yield a satisfactory solution.

Failing this, appeal may be made to an independent physician responsible for supervising the parties to the dispute. This independent physician could be the chief of staff, the chief resident, or the head of the appropriate clinical service. Alternatively, the training institution may assign a particular member of the institutional grievance committee the responsibility for adjudicating disputes requiring immediate resolution.

Another approach worth considering, at least in large institutions, is the appointment of a third-party mediator or ombudsperson who, as discussed above, would be largely outside of the established hospital staff hierarchy. When disputes could not be settled by the parties involved, the ombudsperson could be

brought in to help mediate the dispute.

In some cases, there may be no time for mediation of disputes, even if a third-party mediator or ombudsperson is readily available. In situations where refusal to immediately carry out the attending or supervising physician's orders would threaten patient welfare, the attending physician's orders must be respected, even when it is felt that the orders may themselves harm the patient. For instance, a resident physician assisting in a surgical procedure should not withdraw from the operation or refuse to proceed, even when he or she feels that the surgeon is in error, when to do so would jeopardize the welfare of the patient. When there is time for outside consultation, however, further dialogue can help resolve differences to the benefit of all involved. The role of a third-party mediator, such as the chief of staff, grievance committee member, or ombudsperson, should not be to impose his or her own decisions on the attending physician, except perhaps in the most extreme cases. Rather, the mediator's role should be to facilitate discussion and help all parties reach a satisfactory agreement on how to proceed.

An appeal to a third-party mediator or ombudsperson for immediate dispute resolution is a realistic option only if the trainee or other staff member raising the concerns feels confident that he or she will not penalized as a result. While spurious complaints should certainly be discouraged, it is unlikely that such complaints will be frequent. Trainees are usually reluctant to challenge their supervising physicians and will generally raise concerns only when confronted with situations of clear misconduct resulting in significant harm to patients. Challenges from medical students will almost certainly be less frequent than those from resident physicians, who are much more likely than students to identify with confidence serious errors in clinical management. However, students and resident physicians may be equally able to identify impairment or unethical conduct that threatens patient welfare, and therefore should have access to an ombudsperson or other third-party mediator should the need ever arise.

CONCLUSIONS

Many of the sources of conflict between supervisors and medical students, resident physicians, and other staff can be avoided through open, ongoing communication. Physicians should make their expectations clear to the resident physicians and medical students under their supervision. In addition, they should engage ill open discussion with resident physicians and students about any questions and concerns the residents and students may have. Addressing the concerns that cause disputes between trainees and supervisors, through adequate communication and the pro- motion of clear standards of ethical conduct, will avoid situations in which minor concerns develop into serious problems, and help promote a teacher relationship "based on mutual trust, respect and responsibility."[20]

Ultimately, responsibility for promoting an atmosphere conducive to comfortable, productive teacher-Iearner relationships must fall to all the parties involved: medical supervisors and trainees, the training institution itself, and the larger, university governance structure of which the training institution may be a part. To a great extent, the tone and character of individual interactions can be influenced by strong institutional policies making it clear that mistreatment, abuse, and other unethical conduct will not be tolerated.

RECOMMENDATIONS

For the reasons described in this report, the Council on Ethical and Judicial Affairs recommends that the following guidelines be adopted and the remainder of this report be filed:

1. Clear policies for handling complaints from medical students, resident physicians, or other staff should be established, as outlined in the recommendations of the AMA's Guidelines for Establishing Sexual Harassment Prevention and Grievance Procedures and Council Opinion 9.031: Reporting Impaired,

Incompetent or Unethical Colleagues. Grievance committees or other mechanisms for handling complaints should provide for participation by peers of the medical student or resident physician complainant.

2. Policies for handling complaints should include adequate provisions for protecting the confidentiality of complainants when possible. Retaliatory or punitive actions against those who raise complaints are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee.

3. Mechanisms for adjudicating disputes requiring immediate resolution should be in place. Disputes requiring immediate resolution are defined as those involving serious errors in clinical or ethical judgment, or physician impairment, that result in a threat of imminent harm to the patient or to others. Third-party mediators of such disputes may include the chief of staff or the involved service, the chief resident, a designated member of the institutional grievance committee, or, in large institutions, an institutional ombudsperson largely outside of the established hospital staff hierarchy.

4. In accordance with recommendation 3, medical students, resident physicians, and other staff should refuse to participate in patient care ordered by their supervisors in those rare cases in which the orders reflect serious errors in clinical or ethical judgment, or physician impairment, that result in a threat of imminent harm to the patient. In these rare cases, the complainant may withdraw from the care ordered by the supervisor, provided that withdrawal does not itself threaten the patient's immediate welfare. In any event, it is essential that the student, resident physician, or staff member communicate his or her concerns to the physician issuing the orders and, if necessary, to the appropriate persons for mediating disputes requiring immediate resolution, as defined in recommendation 3 above. Retaliatory or punitive actions against complainants are unethical and are a legitimate cause for filing a grievance with the appropriate institutional committee.

5. Access to employment and evaluation files should be carefully monitored to remove the possibility of inappropriate alteration or tampering. Resident physicians should be permitted access to their employment files and also the right to copy the contents thereof, within the provisions of applicable federal and state laws.

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