From Humiliation to Humanism: Collaboration to Change the Culture of Medical Education

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Disclosures

• Dr. Bensadon is a clinical psychologist hoping to change the culture of medical training/care.

• Mr. Goldszer is a 2\textsuperscript{nd} year medical student hoping to change the culture of medical training/care.

• Mr. Leiser is a 2\textsuperscript{nd} year medical student hoping to change the culture of medical training/care.

• Dr. Obeso is a general internist hoping to change the culture of medical training/care.

**We have nothing else to disclose**
Today’s Plan

1 - Faculty perspective (clinical psychologist)
2 - Trainee perspective (2\textsuperscript{nd} yr medical student)
3 - Trainee perspective (3\textsuperscript{rd} yr medical student)
4 - Faculty perspective (physician)

**unforseen circumstances**

Then...Discussion (Q & A)
Session Discussion Questions

• What contributes to so-called “empathy erosion” and what can be done about it?
• What are the primary under/unrecognized anxieties, concerns, and perceptions of medical students as they progress thru training?
• How can behavioral sciences integration transform the learning environment & better support the well-being of learners, faculty, & patients alike?
Perspective on Psychology of Medical Training & Care (from a clinical psychologist)

Benjamin A. Bensadon, EdM, PhD
Associate Director, Internal Medicine Residency-Geriatrics & Palliative Care Rotation
Assistant Professor of Clinical Biomedical Science
Shameless Plug/Source of Optimism
Traditional Training

• Years 1 & 2 ("pre-clinical")
  – Didactic learning, limited patient contact
  – Basic science/medical knowledge
  – Prepare for & take USMLE exam step 1

• Years 3 & 4 ("clinical")
  – Mostly clinical contact/rotations
  – Mostly hospital-based (inpatient)
  – Lots of patient contact
  – Away rotations
Traditional Training (challenges)

- Limited continuity (w/ pts & attendings)
- Emotional well-being--trainees’, pts’, & role models’--generally not emphasized
- Based on acute care model
- Hazing & shame = common teaching methods
- Culture of silence (e.g., just “suck it up”)}
- Informal (“hidden”) curriculum
On the culture of student abuse in medical school.

Kassabiun DG, Cutter ER

Abstract

The abuse of students is ingrained in medical education, and has shown little amelioration despite numerous publications and righteous declarations by the academic community over the past decades. The culture of abuse conflicts with the renewed commitments of medical educators and practice professionals to imbue students with a higher degree of professionalism and cultural sensitivity. The authors describe the profiles of student abuse, drawn from recent national surveys of medical students using the AAMC Medical School Graduation Questionnaire, and focus on the most common forms of reported mistreatment—public shaming and humiliation—that appear to be misguided efforts to reinforce learning. Along with others, the authors believe that the use of aversive methods to make students learn and behave is likely to foster insensitive and punitive behaviors that are passed down from teacher to learner, a "transgenerational legacy" that leads to future mistreatment of others by those who themselves have been mistreated. The undesirable result is compounded when these behaviors are adopted and directed toward patients and colleagues. The authors advocate more concerted action to curtail the abuse of medical students, citing current and proposed accreditation standards that will be employed more stringently by the LCME, and propose a series of more assertive actions that schools should take. The authors stress that the attitudes, behaviors, and values that students acquire in medical school are as much the products of their socialization as the outcomes of curricular design and pedagogy, and implore medical educators to tidy up the environment for learning.

Beyond curriculum reform: confronting medicine’s hidden curriculum.

Hafferty, F W

Abstract

Throughout this century there have been many efforts to reform the medical curriculum. These efforts have largely been unsuccessful in producing fundamental changes in the training of medical students. The author challenges the traditional notion that changes to medical education are most appropriately made at the level of the curriculum, or the formal educational programs and instruction provided to students. Instead, he proposes that the medical school is best thought of as a "learning environment" and that reform initiatives must be undertaken with an eye to what students learn instead of what they are taught. This alternative framework distinguishes among three interrelated components of medical training: the formal curriculum, the informal curriculum, and the hidden curriculum. The author gives basic definitions of these concepts, and proposes that the hidden curriculum needs particular exploration. To uncover their institution’s hidden curricula, he suggests that educators and administrators examine four areas: institutional policies, evaluation activities, resource-allocation decisions, and institutional "slang." He also describes how accreditation standards and processes might be reformed. He concludes with three recommendations for moving beyond curriculum reform to reconstruct the overall learning environment of medical education, including how best to move forward with the Medical School Objectives Project sponsored by the AAMC.
Feedback?
New Training Model

• Holistic review of medical school applicants
  – Seek more well rounded future physicians
  – Criteria beyond basic science knowledge, test performance, & grades
• MCAT expansion to include psychological & behavioral sciences
• More attention paid to learners’ psychological well-being (depression, anxiety, quality of life)
• More focus on managing chronic conditions/psychosocial aspects of care
• Core competencies (teamwork, communication, professionalism, etc)
• Simulation
Having the Talk: When Treatment Becomes End-of-Life Care

AAMC Reporter: July/August 2015

—By Aliyah Baruchin, special to the Reporter

Conversations about end-of-life care are among the most important interactions doctors and patients have. But for health care providers of all ages, backgrounds, and specialties, they may also prove to be the most challenging.

Decades after the rise of palliative care as a clinical specialty, enormous progress has been made in teaching medical students and clinicians how to navigate end-of-life issues. These conversations have become more crucial because people are living longer with chronic and serious illnesses.

“There may not be anything left to do medically, but there is always something left to do for the patient.”

—Benjamin Bensadon, EdM, PhD
My Role

• **M1 & M2:**
  – Lecture & small group facilitation
  – 8 students/grp

• **Topics**
  – Communicating w/ depressed pts
  – Substance abuse counseling
  – Adherence
  – Health literacy
  – Cultural competence/social determinants of health
  – Professional boundaries
My Role

• M3 & M4
  – Ethics thread (small group facilitation)
  – 16 students, 3-4 case presentations/session
  – Didactic lectures (chronic disease self-management)
  – EoL simulation
  – Cultural competence OSCE
  – Support group & interprofessional case conference exposures at memory & wellness center
  – Weekly general clerkship “debrief”
My Role

• Internal Medicine Residency
  – Noon conference lectures
    • Communication, behavioral health, ethics
  – Teaching rounds
  – Interprofessional case conference

• Future
  – Monthly hospital-wide support groups for clinicians
  – Psychosocial medicine curriculum

• Committees
  – Admissions, Promotions (professionalism)
Medical Student Perspectives on Psychiatry Residency Selection

Isaac Goldszer, MA
2nd year medical student
On my first day of medical school...

...But I learned quickly
“You will all use these skills we’ve taught you in medical school, unless you go into psychiatry.”

Why aren’t we teaching the skills necessary to be an excellent psychotherapist in medical school?

Studies find success in the clinical years is related more to non-cognitive, interpersonal intelligence including empathy. (Haight, Chibnall, Schindler, & Slavin, 2012)
Stigma against the mental health professions and thus mental illness may encourage suffering in silence & avoidance. (Wiesenfeld et al., 2014)

We may be less likely to recognize or address warning signs in our peers, who are 2-3x more likely to complete a suicide attempt than the general public. (Center et al., 2003)
Study at the University of Calgary finds medical students do carry a bias against individuals with mental illness but that interventions can reduce it. 9.7% of the class exposed to intervention matched to psychiatry vs 3.9% for US medical graduates.

(Papish et al., 2013)
“You’re too smart for psychiatry”

This is a dagger in disguise. It is a denial of mental illness as real, dangerous, or difficult to treat. Neurogenetic analysis suggests psychiatric illnesses are actually highly complex.

(Sibille & French, 2013)
High performing student with interest in psychiatry being pushed towards neurology because of a perception of psychiatry as “not challenging enough.”

A Concern
“If you didn’t want to go to medical school, but you have a medical degree, go into psychiatry”

This suggests *psychiatrists aren’t doctors*, and by extension, *psychiatric illness isn’t real*.

Psychiatry has worked to become more scientific but how has the human side of medicine suffered as a result?
“Neurophobia” is a term which has been used in the literature to describe medical student aversion to the neurosciences. Neurology is even less popular than psychiatry with only 2.6% of US medical school graduates matching in 2014.

(Solorzano & Józefowicz, 2015)
“The disciplinary separation of the two major practice arms of clinical neuroscience, psychiatry and neurology, is a conceptual and structural impediment to scientific and clinical progress in the care of people living with complex brain disorders.”

(Reynolds et al., 2009)
Mixed Messages, Empathy Fatigue and Mental Health Concerns in a Prospective Medical Resident.

Scott Leiser, BA
3rd year medical student
Objectives

• Provide some insight into the confusing and often contradictory elements of the clinical portion of undergraduate medical training from the perspective of a non-traditional candidate.

• Discuss some of the ubiquitous mixed messages that inundate medical students during the clinical portion of undergraduate training.

• Address potential concerns about empathy fatigue and mental health support during residency training and discuss what information is available to help the candidate make informed decisions about where to apply based on these criteria.
Some personal background

- 1999: BA, Business, Brown University
- Worked for various Wall Street institutions on both the “sell side” and the “buy side” of equity and derivative research.
- Equity manager at several hedge funds covering technology, particularly computer hardware and its supply chain.
- Almost 9 years of experience in finance before deciding to change course and attend medical school.
- I am a non-traditional student who has completed the first half of the third year at the age of 39.
Growing research on Empathy & Burnout in medical education


Common mixed messages

- **Academic setting** “Medical care is a team effort with the physician taking a leadership role among a cast of characters necessary for patient care.”

- **Clinical setting** “TRUST NO ONE WHEN IT COMES TO YOUR PATIENTS.”

- **Academic setting** “If you need help, just ask. You are not expected to know everything right now.”

- **Clinical setting** “Don’t bother me with this, you should know this already you’re an M3, ask one of the nurses.”

- **Academic setting** “First and foremost: DO NO HARM! If you are not comfortable with a procedure, say so and ask for assistance. Patient safety is priority #1”

- **Clinical setting** “NEVER refuse an opportunity to perform a procedure, you will learn as you go.”
Depression & empathy voltage drop already apparent before the beginning of the M3 year.

- The first time I witnessed widespread suffering in my classmates was in the aftermath of the score reporting for USMLE Step 1. A good number of people began to exhibit signs of major depressive disorder related to the receipt of their scores. Students openly questioned, before setting foot in a clinical care situation, if they “had what it took to be a doctor” or wondered if they were fooling themselves by continuing.

- One student who failed to pass the exam, expressed to me the weekend after that “his wife had had officially married a failure, how am I going to make it up to her? How am I going to provide for my family?“

- Shame is a powerful negative factor in the examination process.

Hidden Curriculum of Medical Culture

• “I think the pendulum has swung too far in one direction, toward making the experience too soft,” the Manhattan internist Robert Press told the New York Times in 2009. “The inmates are running the prison, and it’s a huge challenge.”

• This raises concerns in a potential resident that current culture incentivizes silence. Speaking out about what is happening with them may affect their standing with senior attendings, chances at fellowships, etc.

• The concern for the potential applicant: what resources are in place to help me when I feel like I am drowning, because I WILL FEEL OVERWHELMED.
Ideas from the ACGME Council of Review Committee Residents

• In describing the characteristics of the ideal learning environment to accommodate learners in times of stress, comments encompassed 5 themes:

1. Awareness and destigmatization of mental health issues (“nonjudgmental,” “safe to talk about mental health issues,” “emotional awareness”)
2. Camaraderie (“building a cohesive unit among the residents”)
3. Mentorship by faculty and senior trainees (“positive feedback in tense situations,” “teaching learners to ask for help when needed”)
4. Availability of mental health services (“confidential counseling” by “outside mental health providers”)
5. Supportive culture (“support after bad events,” “knowing that environment would be supportive” irrespective of the outcome).

(Daskivich et al., 2014)
Ideas from the ACGME Council of Review Committee Residents

• Programs I found that provide confidential external mental health services and fit the rigorous schedules of residency training were the University of California, San Diego, Oregon Health & Science University, and the University of South Florida.

• Cost can be a concern but as a framework, to a neophyte applicant, they provide at least some structure of how to determine if the work environment for the next several years will foster and protect the humanistic, patient-centered approach to care that our academic institutions are pushing in the classroom.
Discussion

• Questions/Thoughts/Comments?