Dear Program Director: Solutions for Handling and Preventing Abusive Behaviors During Surgical Residency Training

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ABSTRACT

The prevalence of abusive behaviors including bullying, discrimination, harassment, and sexual harassment experienced by orthopaedic residents during their surgical training is alarmingly high. Fear of retaliation and detriment to one's career are two common reasons for lack of reporting and filing complaints regarding these abusive behaviors. The #SpeakUpOrtho campaign recently raised awareness of how prevalent these behaviors can be during orthopaedic residency training; therefore, this Call to Action aims to present solutions for handling and preventing abusive behaviors during training.

Women account for only 15% of orthopaedic residents in the United States as recently as 2018 to 2019 and are among the lowest representation in surgical subspecialties.[1] There are multiple reasons speculated. A survey of orthopaedic workplace culture conducted through the American Academy of Orthopaedic Surgeons in 2019 found that 81% of female respondents had experienced bullying, discrimination, harassment, or sexual harassment.[1] This is alarmingly high. The problem is documented, but solutions are not. The culture permits this to occur. More concerning is that 68% of women in orthopaedic surgery residency report the experience of sexual harassment during training.[2] Fnais et al[3] reported that 59% of medical trainees experienced at least one form of harassment or discrimination during their training. These percentages indicate a problem exists and can be a predominant factor in gender disparity in orthopaedic surgery. There is a lack of data to examine the role these behaviors play as medical students choose their specialty.

#SpeakUpOrtho was founded on the premise that the culture of orthopaedic residency dissuades women from choosing the field of orthopaedics. Orthopaedic trainees who experience harassment and bullying are unlikely to report these behaviors. The most common reason for a trainee not to report is fear of retaliation.[4,5] A second barrier to reporting may be "normalization of deviant behavior," which occurs when people in a work environment become desensitized to unacceptable behavior because of its pervasiveness. Finally, a third barrier to reporting is a lack of trust in the

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reporting process. Human Resources may be viewed by many to prioritize the interest of the organization over the individual. For these reasons, the founders of #SpeakUpOrtho gathered together to create a safe and anonymous space to tell stories and affect change.

Submitted Experiences of Orthopaedic Residents During Training

In writing this commentary, we collaborated with #SpeakUpOrtho to obtain anonymously submitted stories from orthopaedic surgery residents to gain insight into their experiences during their surgical training. #SpeakUpOrtho is a campaign that has recently gained increased attention on social media platforms, providing an anonymous forum through which individuals can submit their personal experiences to make their voices heard in a safe environment. #SpeakUpOrtho is raising awareness demonstrating the high prevalence of abusive behaviors including bullying, discrimination, sexual harassment, and harassment during orthopaedic surgery residency training and beyond. An online survey portal was used where respondents were able to access and respond to the following four statements:

1. Awareness: Please tell us your story that you would like to submit for use on the #SpeakUpOrtho social media platform.
2. Reporting Experience: Please tell us your experience when you tried to report an abusive behavior. Was the situation resolved? Did you face retaliation? Help us understand the process you experienced.
3. Advocacy: Please share instances in which you have witnessed or have been directly a part of active bystander advocacy when there has been bias, harassment, or abuse.
4. Action: Share your ideas for creating a better work environment so that we can use your recommendations to implement change.

Thematic analysis of 200 orthopaedic resident stories that were submitted between March 2021 and May 2021 was done by members of #SpeakUpOrtho in a qualitative fashion to determine the most commonly experienced abusive behaviors, the offenders of the behaviors, and the experience of those who reported the behaviors.

The five most commonly submitted abusive behaviors included the following: (1) sexual harassment, (2) bullying, (3) harassment, (4) sex discrimination, and (5) microaggressions. The most commonly reported offender of these behaviors included: (1) attending physician, (2) senior orthopaedic surgery resident, (3) program director/chairman, (4) nurse, and (5) patient. Most individuals who wrote that they did not report this negative behavior to their program or institution stated that this was due to fear of retaliation, fear of detriment to their career, or fear that they would be judged negatively within the program. Responses from individuals who wrote that they had a negative experience when reporting these behaviors to the institution stated this was due to a lack of confidentiality within the reporting process, lack of accountability, and consequence to the offender ("nothing was done") and that they faced retaliation after the complaint. The few responses that were submitted that showed a positive experience when reporting the behavior demonstrated that the institution took the complaints seriously, kept the victim safe through confidential reporting, and took some form of initial action to mediate the resident-physician interaction holding the perpetrator accountable for his/her actions.

Solutions to Address Abusive Behaviors During Residency

Culture of the Program/Institution

Creating a surgical training environment that is inclusive and supportive is critical in the development of each resident. It is important for leadership to encourage professionalism and implement a zero tolerance policy

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when there is workplace bullying, harassment, sexual harassment, or discrimination. "Top down" initiatives can define the culture of the program, and advocacy of resident well-being through mentorship programs can be useful in ensuring that these behaviors do not occur.

Defining and Educating

It is important to educate on the parameters of acceptable workplace behaviors and define what behaviors qualify as bullying, sexual harassment, harassment, and discrimination. Compulsory education regarding the identification of these behaviors, strategies for correcting these behaviors, and methods for sustaining change in behaviors should be implemented in each institution.[6] Team-based simulation training modules can be used in the curriculum to help provide additional training with real-life scenarios. A recent Harvard Business Review article underscored the importance of having policies instituted containing guidelines for standards of behavior; employee reporting of inappropriate behaviors; and institutional responses to abusive behaviors, discrimination, and retaliation.[7] Finally, residents should also be educated on how to report behaviors in a safe and confidential manner.

Code of Conduct

The ACGME Common Program Requirements state "Programs must provide a professional, respectful and civil environment that is free from mistreatment, abuse or coercion of students, residents, faculty and staff."[8] The inherent problem with this is professionalism is difficult to teach, to evaluate objectively, and to define. In a CORR editorial, normative errors in professionalism were defined as "derelictions that violate foundational professional values, such as honesty and integrity," and are often unforgivable offenses and difficult to admit.[9] Discrimination, bullying, and harassment behavior would fall into this category. By developing a Code of Conduct for those involved in surgical training and academic medicine, objectification of these normative errors would be defined, and it would be easier to define these undesired behaviors.

Title IX Mandatory Reporting

Title IX of the Education Amendments Act of 1972 (Figure 1) applies to institutions that receive federal financial assistance from the US Department of Education. Every school must have and distribute a policy against sex discrimination, and every school must have a Title IX coordinator who oversees all complaints of sex discrimination.[10] Faculty are required to promptly report complaints or concerns of sexual misconduct to the Title IX coordinator; this includes incidents that are personally observed and incidents reported to the faculty member.[10] Mandatory reporting distinguishes and elevates Title IX concerns. All faculty and department leadership should understand what issues are included under Title IX, that prompt reporting is mandatory, and where to report these complaints or concerns.

Reporting Process and Implementation of Confidentiality

It is crucial to have a protocol implemented that allows for confidential reporting of abusive behaviors. This reporting system must be reliable and safe with clear instructions on how to access and use the system. Importantly, residents believe that their complaints will not be ignored and that they will be able to report without being retaliated against. Pathways for initial anonymous reporting may include an anonymous online portal, periodic surveys, or questionnaires.[11] Confidentiality in these situations, although, is usually "to the extent possible" which is defined as confidentiality from all those persons who do not have a "need to know" of the complaint.[12] Assurance of nonretaliation should also be associated with the confidentiality protocol. Defined consequences should be established and implemented in the event where confidentiality is breached and/or retaliative action has occurred.

Designated Resident Advocate, Third-Party Professional

A designated resident advocate (DRA) may be a useful option as the first line of communication when reporting abusive behaviors. The role of the DRA should be to listen to the concerns of the individual filing the complaint, determine whether the situation can be managed at a resident level or deem it necessary to escalate to a leader in the program, and help serve as a neutral third party to mitigate communication between the resident and the program. This avenue for reporting should also be confidential, and residents who serve as the DRA should be held to the same standards where consequences, including probation, will be implemented if there is a breach in confidentiality.

A third party of trained professionals may be beneficial when implementing confidential reporting mechanisms for residents to file complaints. This should consist of a group of individuals who serve as independent investigators when reviewing the complaint of the resident to eliminate any bias that those directly involved with the program may have. We recommend that each hospital

Figure 1

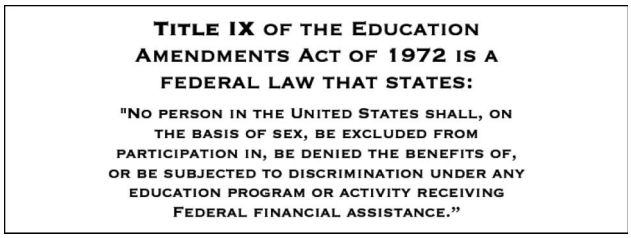

Diagram showing Title IX of the Education Amendments Act of 1972.

institution have an established group of individuals designated to oversee filed complaints. In addition, governing bodies, including the ACGME, should also develop a panel of individuals to provide oversight and advice when a resolution cannot be obtained at the institutional level.

Ombudsperson

There is a high rate of not reporting concerns regarding bullying and harassment, and the leading reasons for this are fear of retaliation or of inaction, that nothing will change. An ombuds office or ombudsperson provides an impartial forum and can help combat disincentives for trainees to report.[13] An ombuds office operates independently and has no formal decision-making authority or disciplinary responsibilities. The ombudsperson should not be associated with department leadership and ideally should have no reporting requirement. The goal is to ensure safe reporting with no concerns of retribution or retaliation. The ombudsperson advocates for fair treatment and processes and can facilitate an impartial investigation and maintain anonymity of the trainee. As of 2015, more than 35 medical schools in the United States have active ombuds webpages.[13]

Defined Consequences for Perpetrators

It is critical to have a zero tolerance policy, and as part of this policy, there must be defined consequences for perpetrators, regardless of where they exist on the hierarchy. For trainees, there should be standardized processes for remediation, probation, and termination.[14] Program directors oversee resident remediation and work within the confines of the Graduate Medical Education (GME) office, the clinical department, human resources, and the legal department.[14] There should be a standing probationary committee so that any decisions are not unilateral; this committee will use the thoroughly amassed information to determine corrective actions. With the first transgression, the committee members may consider placing the trainee on focused review or probation, with frequent check-ins with an assigned faculty mentor. Trainees need to understand that these behaviors are never events and that they are under constant evaluation. For severe digressions, or for repeat offenses, they may even be terminated. For faculty members, there should be a similar process of close observation with an assigned senior mentor for required meetings and close evaluations.

Support for Victims

It is critical to provide support for victims because many studies demonstrate that such abuse induces stress; impairs performance; and can lead to depression, anxiety, insomnia, alcohol abuse, and appetite loss.[15–17] Support can be informal or formal within the department, through faculty mentorship. The GME also has options for trainees to seek support outside of the department. There should also be an opportunity to obtain services external to the institution. All of these options should maintain the utmost confidentiality for the victim.

Bystander Intervention and Simulation Training

Many offensive acts that occur are often witnessed by others. That includes medical students, trainees, nurses, operating room support staff, and other surgeons. Often, people are not comfortable stepping in or up to the perpetrator. It is important to address actions as they occur and to help the victim. Often, the power imbalance is a big deterrent in speaking up. The iHollaback! provides training on how to do your part to protect others when witnessing these events.[18] This is termed "the 5 D's of bystander intervention" and gives 5 different methods to support someone who is being bullied or harassed (Table 1). It is our goal that this be part of mandatory training in residency programs and be handed out on a card to put in with one's hospital identification badges.

Vetting of Leaders, Program Directors, and Chairs

The studies demonstrate those who are perpetrators are often those in authority.[2,6,11] It is the traits that make one a good leader that also permits them to be aggressors. It is the leaders who set the culture for the organization. The culture cannot change if the aggressors are in power. We suggest that everyone applying for faculty position, program directors, chairs, specialty society and American Academy of Orthopaedic Surgeons Committee chairs, Board of Directors positions, and American Board of Orthopaedic Surgery examiners be vetted for their commitment to an environment free of discrimination, bullying, and harassment. Ideally, a question "Have you ever been accused of discrimination, bullying or harassment?"

Table 1. The 5 D's of Bystander Intervention[18]

Direct	Let the offender know this behavior is not acceptable.
Distract	Change the course of the event by drawing attention away.
Delegate	Delegate to someone for help, a person in authority.
Delay	Support the person after the event, ask if they want to talk.
Document	Document your witnessing of the event.

could be asked. The response might not be honest or forthcoming. However, it causes a pause and lets others know that this behavior is not tolerated. Although it would not necessarily exclude someone for positions, it makes the organization aware, understanding it is possible to have learned from these instances and be a contributor to a positive culture.

Not Permitting Offenders to Have Residents on Their Service

The Program Director can control the attendings who rotate with residents.[8] If an attending has received continual negative reviews for various reasons, which may include actions such as persistent complaints regarding resident autonomy to outright discriminatory, bully, or harassment behavior, the Program Director may remove residents from his/her service. In meeting with residents, the Program Director should speak with the residents about their experiences on each rotation. Over time, the residents may not always speak up, but even the reactions and hesitancy to discuss a certain rotation should lead the Program Director to investigate the true sources of residents' complaints or even silence.

Conclusion

The creation of a culture that promotes a healthy, equitable teaching environment with accountability for offensive behaviors will not only improve the diversity of the specialty but will positively affect healthcare delivery. The high rates of bullying, discrimination, harassment, and sexual harassment during surgical training is concerning, with most complaints going unreported because of residents' fear of retaliation and detriment to their careers. This Call to Action provides solutions for handling and preventing abusive behaviors during surgical training while ensuring a safe platform for individuals to voice complaints.

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