The Other Side of Medical Student Mistreatment: Teaching Cultural Competency Across the Generational Divide

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Abstract

Introduction: Medical student mistreatment continues to be a significant problem despite increased awareness and longitudinal efforts to address the issue. Through audience discussions of a previously published film depicting learner mistreatment, we identified challenges created by student behaviors that negatively impact the learning environment. In addition, the need to address cultural competency in a multigenerational clinical environment became apparent. Methods: We created a film of three vignettes based on perspectives shared in focus groups by faculty, residents, nurses, and staff who work with medical students. We used this film to develop student and faculty curricula elucidating generational differences in behaviors and expectations while also exploring the learner’s role in creating a more positive learning environment. Results: Our film was presented to medical education professionals at faculty development workshops and meetings, clerkship students at orientation sessions, residents as part of residents-as-teachers curricula, and faculty at departmental grand rounds. Evaluation data from 176 students and 42 faculty showed that a majority of our participants believed the film accurately reflected challenges they faced in the learning environment and felt better equipped to address them. Discussion: Film is an effective way to stimulate discussion about complex interactions in the clinical learning environment. Divergent perspectives on behaviors depicted in the film served as a stimulus to create targeted curricula for faculty and student education. Stimulating dialogue through film may enhance understanding and empathy among disparate groups, which is likely to be a necessary step for lasting change.

Keywords
Learning Environment, Mistreatment, Generational Competence, Film Curriculum, Case-Based Learning, Clinical Teaching/Bedside Teaching, Problem-Based Learning

Educational Objectives

After participating in this session, learners will be able to:

1. Promote and facilitate discussion on the topic of student mistreatment, using film as a prompt.
2. Identify four system changes and five generation-based challenges that may contribute to conflicts among faculty, residents, nurses, staff, and students in the medical education learning environment.
3. Develop and review four best practices for navigating system changes and bridging generational divides within the medical education learning environment.

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Introduction

Despite increased awareness of the problem of medical student mistreatment, national rates have remained stable over time. While it is agreed that institution-wide, multifaceted efforts are necessary to address this intransigent problem, even well-designed, decade-long efforts can be unsuccessful. One significant challenge is that the concept of learner mistreatment is nuanced and susceptible to multiple (and sometimes divergent) interpretations. To address this challenge, the University of Vermont Larner College of Medicine previously developed and published in MedEdPORTAL a film/discussion curriculum and self-study module designed to convey the perspective of learners on the topic of mistreatment. In keeping with most published guidelines and initiatives on how to address mistreatment, this one was largely focused on the role of educators in the problem and on faculty development. Motivated by powerful audience discussions around our curriculum, we learned that missing from our initial effort was...
a discussion on the role of the learner in creating a positive learning environment. This neglect of the student role is also reflected by the paucity of literature focused on the student’s contribution toward building a positive multigenerational learning environment.

Although other video-based and narrative-based curricula address medical student mistreatment in the clinical learning environment, this film and curriculum aim to illustrate the other side of mistreatment. Specifically, this film is unique in depicting the perspectives and challenges identified by faculty, residents, nurses, and staff in working with medical students. It is built on the premise that learners can gain valuable insight by participating in a curriculum designed to expose them to the views of educators so that they, too, might consider altering their expectations and behaviors in the learning environment. It is designed to be administered to medical students and all faculty, residents, staff, and nurses who participate in the training of medical students and can be presented as a standalone curriculum or in series with our previously published MedEdPORTAL curriculum on the student perspective on learner mistreatment. It is our hypothesis that depicting both sides of learner-teacher interactions to all stakeholders in the learning environment is necessary to reduce defensiveness and promote the level of mutual empathy we believe is essential to create what Leape et al. have termed a culture of respect in medicine.

Methods
Focus Groups
In January 2015, we obtained local grant funding (University Health Center Trust and University of Vermont Medical Group Teaching Award) to create a learning environment film (Appendix A: UVMCOM Film2) depicting the perspectives of faculty, nurses, staff, and residents. We conducted 10 focus groups across three clinical sites (the University of Vermont Medical Center [UVMMC] and two affiliates) as follows: four nursing groups, three clinical faculty groups, one basic science faculty group, one resident group, and one Office of Medical Student Education staff group.

Film Development
From the transcribed focus group narratives, we identified common themes that were used to create scenarios for the film script. The three scenarios in the film covered discussion topics such as the use of technology, promoting a spirit of inquiry, the importance of setting clear expectations, enhancing learner engagement, constructive feedback, nurse–medical student interactions, and attendance and punctuality (Appendix C: Facilitator’s Guide). One member of our group (Sean F. Ackerman, MD), a film director and child psychiatrist, wrote the script and directed the film. We cast amateur volunteer actors in parts corresponding to their actual role in medicine and filmed on location at UVMMC using a professional production crew.

Film Screening
We screened the resulting 5-minute film with 20 medical students across different years to collect comments, then solicited help from four current fourth-year medical students to identify teaching points (e.g., best practices) for student viewers. We also screened the film in several faculty workshops, collecting reactions and best practices from these audiences.

Curriculum Development
We then developed two separate film/discussion curricula around the film: one for student education and one for faculty development. Teaching points for faculty (nurses, residents, and staff) and students are summarized in Table 1 and discussed in the Facilitator’s Guide (Appendix C). In each curriculum, film viewing was accompanied by a slide deck presentation exploring general themes related to learning environment challenges (Appendix B: Other Side of Mistreatment) and was followed by a facilitator-led discussion on each of the film’s scenarios, including a summary of best practices derived from focus group themes, prior audiences, and the literature (Appendix C). As our ideas developed, we also began to use the film as a stimulus to discuss system changes and generational differences in medicine, with the aim of enhancing cultural humility across generational gaps (Table 2).

Data Collection
We presented this curriculum in the following contexts:

- Three clerkship orientation sessions (students).
- Two departmental grand rounds (faculty, nurses, staff, and students).
- Two faculty development sessions (faculty).
- One nursing development session (nurses).

We collected audience response data from the three clerkship sessions and the two departmental grand rounds on the impact of this curriculum (Appendix D: Session Evaluation). To facilitate cross-generational communication, these sessions were facilitated by a group of core faculty involved with film development, residents, and medical students. Those who attended had the option to answer evaluation questions directly after the film screening using audience response technology. Questions in these sessions focused on respondent characteristics, perceptions, and experience in witnessing events.
Table 1. Scenario Themes and Teaching Points

| Scenario | Focus Group Themes Depicted | Student | Faculty/Staff |
|----------|-----------------------------|---------|--------------|
| A        | Disinterested student, Overeager student, Possible one-upmanship, Technology-preoccupied student, Entitled student, Generational differences, Cultural shifts in medicine with protection of trainees but not attendings | Practice techniques to engage faculty (introduce self, be curious, be prepared), Immerse yourself in the specialty you are learning, Be humble, ask for help when needed, Be aware of how faculty may perceive use of technology—be transparent with its use, Have respect for generational differences in the workplace, appreciate experience of older generations, Seek opportunities to express gratitude | Make effort to get to know students, Practice good feedback skills with specific guidance on ways to improve, Be curious before making assumptions, Keep in mind that some learning environments (e.g., the operating room) can be intimidating, Have respect for generational differences in the workplace, appreciate the positive attributes of younger generations (e.g., being tech savvy), Communicate explicit expectations early, Periodically communicate clinical relevance or rationale for content, Be aware of own biases, recalibrate assumptions about the use of technology |
| B        | Student lateness and lack of preparation, Inappropriate dress, Feedback: Where? When? How?, Impact of receiving post hoc reports of mistreatment rather than direct feedback | Acknowledge when late, accept responsibility and apologize, Mutual respect is important; show respect for resident and attending work hours/workload, One’s attire is a form of communication; look at it through the eyes of patients, families, and other professionals, Be humble: Listen well and be open to alternative points of view, Be respectful with written feedback | Direct feedback should be specific, constructive, and behavior based, Attempt to provide personal feedback in private if possible, Invite feedback from students, Be aware that students fear retaliation if they provide earnest feedback directly, Be humble: Listen well and be open to alternative points of view, Be aware of generational and gender differences in (and about) dress, Be aware of own biases, recalibrate assumptions about dress |
| C        | Student’s lack of situational awareness, Student agenda conflicting with nursing agenda, Nurse’s role in protecting patients, Importance of interprofessional education, Hierarchical tension between medical students and nurses | Be aware of your surroundings, Ask: “Would this be an OK time?” or “Am I interrupting?” | Interprofessional dialogue and teaching are desired, Be aware of the pressure on students to get assignments done, Preface your observations with “it seemed to me” rather than sharing an assumption as reality, What may look like entitled behavior may be lack of acculturation to the clinical setting |

Table 2. Generational Conflict and Teaching Points

| Generational Conflict | Scenario | A | B | C | Cross-Cultural Teaching Point |
|-----------------------|----------|---|---|---|-------------------------------|
| Millennials accustomed to being told they are special; traditionalists/boomers perceive students as entitled |       | ✓ |   | Teach and model humility in the workplace, Approach interactions with a spirit of inquiry |
| Millennials have difficulty accepting constructive criticism | ✓ ✓ ✓ | ✓ |   | Teach and model openness to criticism or negative feedback |
| Millennials as “technology natives” expect unlimited access to the internet; traditionalists/boomers perceive technology use during teaching as rude | ✓ ✓ ✓ | ✓ |   | Set expectation about technology use in advance of lecture or rotation, Be transparent in use of technology |
| 25% of millennials do not regard punctuality/attendance as a professional attribute; faculty perceive lateness or not attending as rude | ✓ ✓ ✓ | ✓ |   | Set explicit expectation about punctuality and attendance in advance, Faculty need to adapt to and accept some student preferences (e.g., asynchronous and multimodal learning) |
| Millennials are interested in “work to live”; traditionalists/boomers perceive that philosophy as lack of work ethic or professional commitment | ✓ ✓ ✓ | ✓ |   | Millennial insistence on improved work/life balance might be good for everyone in medicine |
| Millennials are less hierarchical, insist on more respect, and speak out about perceived inequities; faculty experience this as challenging and too informal or rude | ✓ ✓ ✓ | ✓ |   | Outspoken millennials might promote more respectful learning environments, Less hierarchy in medicine might improve communication, collaboration, teamwork, and patient safety |
related to student behaviors that may contribute to conflicts within the learning environment. We collected these data using TurningPoint software version 7.5.8.1 (Turning Technologies, Youngstown, Ohio) and used SPSS version 24 (IBM, Armonk, New York) to analyze results. This research was granted exempt status by the University of Vermont institutional review board on January 5, 2017 (CHRMS 17-0286).

Implementation
We presented this curriculum to audiences with as few as 10 (faculty development workshops) and as many as 110 participants (whole-class orientation). The film and discussion session can be completed in an hour, although we found that 75 minutes is optimal to secure enough time for discussion. Standard slide-deck projection equipment with video capability is required. The use of audience response technology is ideal for minimizing barriers to participation and is a useful way to tally honest reflections on each of the scenarios depicted. This curriculum is applicable to both students and faculty and can be administered, as well, to mixed audiences (e.g., grand rounds).

Results
Evaluation Data
We collected evaluation data from 176 students after they participated in our film/discussion curriculum in two grand rounds sessions (psychiatry and anesthesiology), two clerkship orientation sessions, and one clerkship bridge session. Most of the students (47%) were 20-30 years old, 45% were 31-40 years old, and 8% were 41 years or older. Fifty percent were female, 46.3% were male, and 3.8% chose “other” as their gender.

Evaluations from our faculty development workshop in September 2017 rated the session as excellent (5 of 5) and commented, “We had a great discussion about the problem.”

We also collected evaluation data from 42 educators (residents, fellows, and community or academic faculty) participating in the curriculum as part of grand rounds in psychiatry and anesthesiology. Eight percent of respondents were 20-30 years old, 44% were 31-40 years old, 17% were 41-50 years old, and 31% were 51 years or older. A majority of faculty were male (75%), 17% were female, and 8% denoted their gender as “other.”

Identifying common challenges: A sizable majority (95%) of viewers reported that this film resonated with them. Within the overall student cohort, 26% reported having engaged in some or all of the challenging behaviors shown in the film more than once a month, and 36% reported witnessing some or all of the challenging behaviors in fellow students more than once a month. In a smaller subset of students queried about whether they had witnessed the behaviors portrayed in each specific scenario (n = 33), all reported witnessing behaviors depicted in Scenarios 1 and 3 and 94% (n = 30) reported witnessing behaviors illustrated in Scenario 2 in fellow students. Most students reported having done nothing when they witnessed the behaviors in their fellow students (45% for Scenario 1, 53% for Scenario 2, and 90% for Scenario 3). Some comments from the sessions included the following: “I loved how the video provided ‘could-be-real’ examples” and “extremely well done.”

Generational differences: Overall, 70% of respondents (n = 118) agreed or strongly agreed that the film helped them rethink previously held assumptions about people from generations different from their own. These results did not differ based on whether a respondent was a student or educator (p = .342).

Impact of the film: After viewing the film, a majority of students (73%) and educators (87%) felt better equipped to address challenges in the learning environment. Additionally, 75% of students reported increased understanding of the faculty, resident, nurse, and staff perspective related to the challenging student behaviors depicted in the film. More than half of students (55%) responded that they were more likely to change their behavior after viewing the film.

Discussion
We learned that viewing a short, high-quality film was an effective way to stimulate rich discussion about the complex interpersonal interactions encountered in the clinical learning environment. In particular, we found that this film engaged the audience and elicited strong reactions because it seemed to trigger defensive group-affiliation responses (e.g., student in defense of student, faculty of faculty). Although this presented challenges in multigenerational audiences, it also presented great opportunities because we found the audience cross talk (e.g., across the learner-teacher divide) to be highly informative. The interprofessional and intergenerational dialogue often led to an enriched participant understanding of generational tendencies impacting the learning environment. We discovered that the behaviors depicted in the scenarios occurred frequently and that students did not initially understand the impact these behaviors could have on others. However, after participating in the curriculum and being made aware of differing perspectives, a majority of students reported they were likely to change their behavior. Faculty also gained understanding of student perspectives and felt better equipped to address these behaviors when observing them in the future.
In addition, we discovered that teaching points and best practices differed considerably between groups such that two separate curricula were needed—one for students and one for faculty, staff, and nurses. We discovered that reviewing the faculty curriculum with students helped validate their experience; similarly, sharing the student curriculum with faculty helped faculty understand what students were being taught. We also found that periodically mentioning what was being taught to the alternate group helped minimize defensiveness because, not surprisingly, no one group wants to be the sole target of education, thereby, by implication, shouldering the blame for learning environment conflicts.

One unique aspect of our curriculum is that we have solicited resident and medical student contributions at each phase of curriculum development. Because students and junior residents are the closest to the student experience, we have found that including them as cofacilitators for the presentations and discussions optimizes participation. At our institution, in series with our first film/discussion session about medical student mistreatment from the student perspective,3 students engage in this teacher perspective film and discussion as part of their weeklong annual student clerkship orientation. This combined curriculum conveys important messages about our institution’s commitment to a positive learning environment. It demonstrates that responsibility for a positive learning environment is shared by everybody and that cross-generational dialogue is needed to optimally participate in the multigenerational and interprofessional environment of health care.

To date, this curriculum has also been presented in faculty development sessions (e.g., during designated grand rounds or faculty meetings/retreats) and in resident-as-teacher seminar series. We have made our curriculum available to all departments and affiliate sites where medical students are present and believe that the film and discussion points are generalizable to many clinical learning environments.

Although the film and discussions have been positively assessed by our surveys, it is unclear whether they have resulted in lasting behavioral change at the individual level, a demonstrable impact on the learning environment, or improved interactions among faculty, residents, nursing staff, and medical students. Further research is needed to assess the longer-term impact of our film-based discussion curriculum on measures such as AAMC Medical School Graduation Questionnaire mistreatment data. Another limitation of this curriculum is that it runs the risk of falsely ascribing all student mistreatment to a lack of generational cultural humility, which is not our intention. If this curriculum is used independently of our first-film curriculum, it is important to provide the overall context of the problem of student mistreatment, being sure to signify that conflict derived from generational differences is just one element of a much larger problem.

Finally, our two films do not achieve a full 360-degree perspective on the clinical learning environment because the perspective of patients and families is not fully represented. This is a worthy next project for our group given the negative impact that conflict within the clinical learning environment may have on our shared goal of providing patient-centered care.

Despite these limitations, we believe that stimulating inter- and intraprofessional dialogue by providing a realistic depiction of the complexity of the mistreatment problem has the power to enhance understanding and empathy among disparate groups. This is likely a necessary step toward creating lasting improvements in the learning environment.

Appendices

A. UVMCOM Film2.mp4
B. Other Side of Mistreatment.pptx
C. Facilitator’s Guide.docx
D. Session Evaluation.docx

All appendices are peer reviewed as integral parts of the Original Publication.
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Informed Consent
All identifiable persons in this resource have granted their permission.

Ethical Approval
The University of Vermont institutional review board approved this study.

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