Creating and Supporting Safe Clinical Learning Environments: What can I do?

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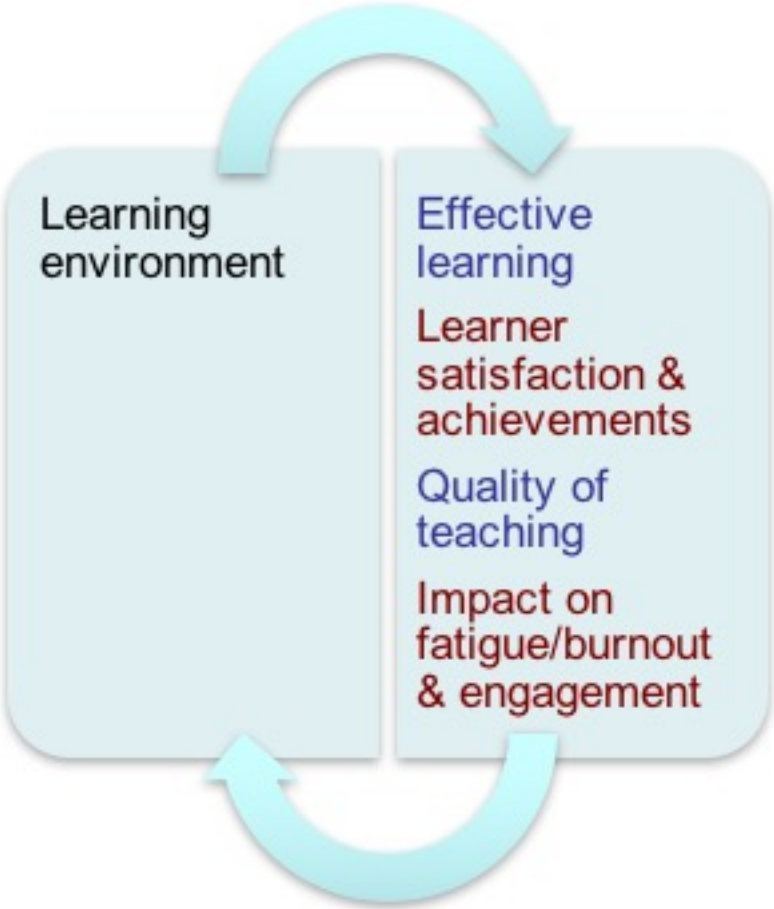
Learning Environment: Why care?



Learning Environment is an explicit accreditation standard

What makes a good clinical Teacher?

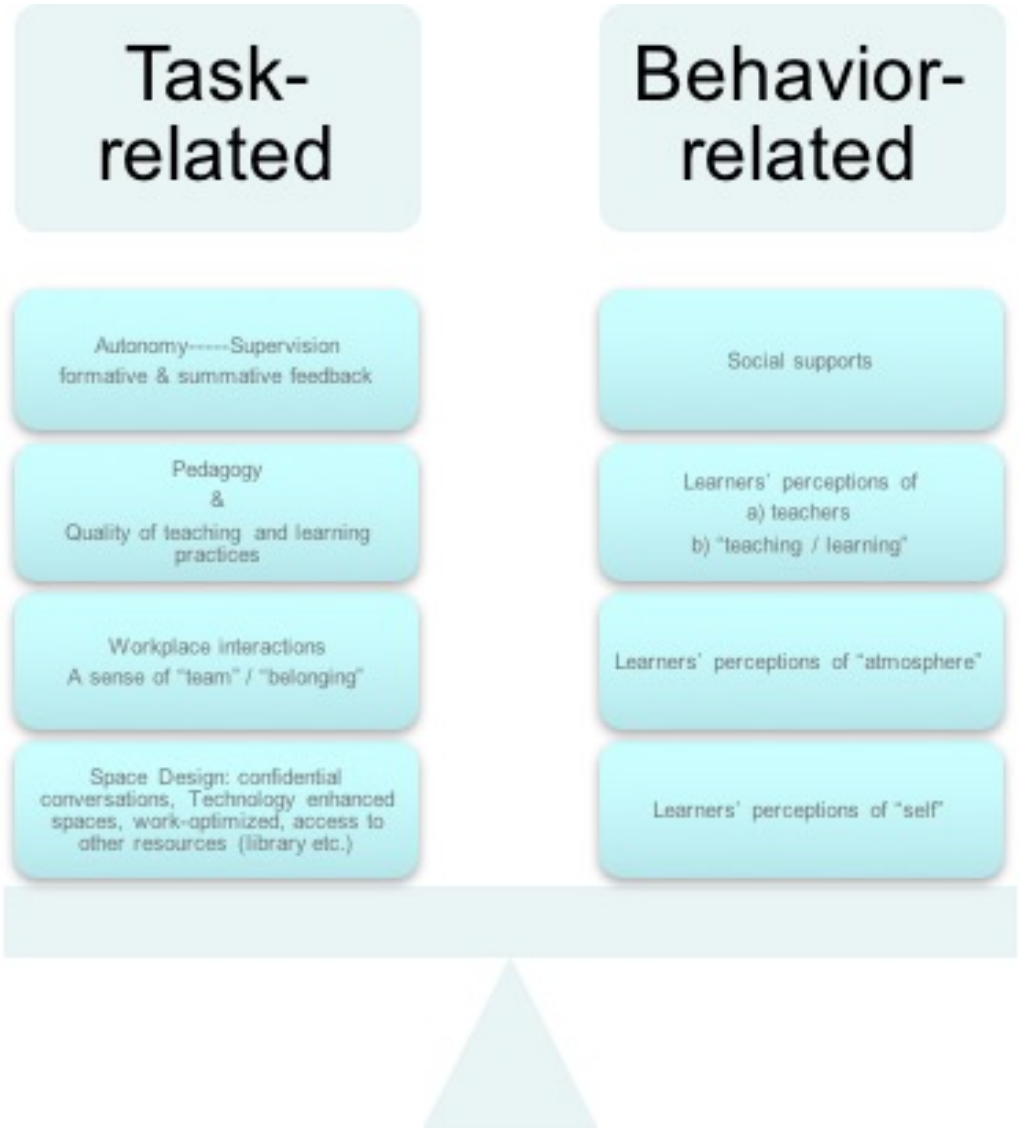
- Medical/Clinical knowledge
- Clinical and technical skills/competence, clinical reasoning
- Positive relationship with students and positive learning environment
- Communication skills
- Enthusiasm

- Academic Medicine 2008, Sutkin et.al

Components of the Learning Environment

What would you think are some components of a safe learning environment

Safe Learning Environment



Learning Environment

- The learning environment has been defined as everything that is happening in the classroom or department or faculty or university

(Genn, 2001, Roff and McAleer, 2001; Cinar, Cakmak & Uzunboylu 2009).

Unsafe Learning Environment

- What do you think are some characteristics of an unsafe learning environment?
- Or what could go wrong?

Excellent Learning Environment

- Behavioral
- Clinical
- Physical
- Learning
- Program

- **Behavioral**

a) **Respectful**
b) Collaborative
c) **Professional**
d) **Learner role valued**
e) **Collegial**
f) **Intimidation is not tolerated**
g) **Harassment is not tolerated**
h) **Misogyny is not tolerated**
i) Racial, ethnic, sexual orientation bias is not tolerated
j) **Free from faculty and/or staff conflict**
k) **Free from faculty and/or staff politics**
l) **Speaking truth to power is encouraged**

- **Clinical**

a) Competence/excellence

b) Variety in learning opportunities/venues

c) Patients align with objectives

d) Clinical workload manageable

e) Patients are safe

f) Staff are safe

g) Appropriate Supervision available

h) Clinical responsibility at the level of the learner

i) Clinical environment is adequately staffed

- **Physical**

a) **Personal physical safety**
b) **Call rooms**
c) **Computer access**
d) **Library access**
e) **Learning spaces (meeting rooms)**
f) **Heat and air conditioning**
g) **Nutrition available**
h) **Accommodations (safe and comfortable)**
i) **Travel is minimum and safe**

- **Learning**

  a) **Good pimping only**

  b) Assessment is fair

  c) **Constructive feedback is timely**

  d) IPE valued

- Program

a) **Leadership is effective**
b) **Program evaluation is valued and implemented**
c) Objectives clear and obtainable
d) Assessment is transparent and fair
e) **Promotion is transparent and fair**
f) Learners are represented
g) Selection is fair and transparent
h) Remediation is well-designed
i) Excellent academic programming
j) **Research supported and resourced**
k) **Administration is adequately resourced**
l) **Resident off-time rules are respected**
m) Time to learn
n) Resident leadership valued and supported

Some Common Disruptive Behaviours

- **By Faculty**
- Rudeness
- Being condescending or demeaning
- Passing judgement
- Shaming learners
- Boundary violations with patients, family members, staff, or other care providers
- Outburst of anger
- Creating rigid or inflexible barriers to requests for guidance or cooperation

- **By Learners**
- Negative comments about team members
- Refusal to learn or comply
- Not working collaboratively
- Unmanaged interpersonal conflict
- Inappropriate jokes or comments
- Profane Language

Disruptive behaviour impacts team relationships and quality of health care delivery, and may lead to emulation of such behaviour.

Exercise on possible underlying root causes of disruptive behaviors

- Small group work (5 min.)
- Large group discussion (5 min.)

Root Cause Analysis of Disruptive Behaviour

- There is commonly an underlying cause to disruptive behavior
- Linked to personal factors, interactions or working environment
- Identifying WHAT, HOW and WHY certain behaviour happened helps develop corrective measures and prevent reoccurrence

"If you don't ask the right questions, you don't get the right answers. A question asked in the right way often points to its own answer. Asking questions is the ABC of diagnosis. Only the inquiring mind solves problems." – Edward Hodnett

Common Root Causes

Personal

- Lack of awareness
- Lack of skill
- Emergent work situations in acute settings
- Stress
- Personal Health issues

System

- Workplace culture / group think (specialty-specific) / “Normalized”
- HHR shortage
- How the learners are viewed

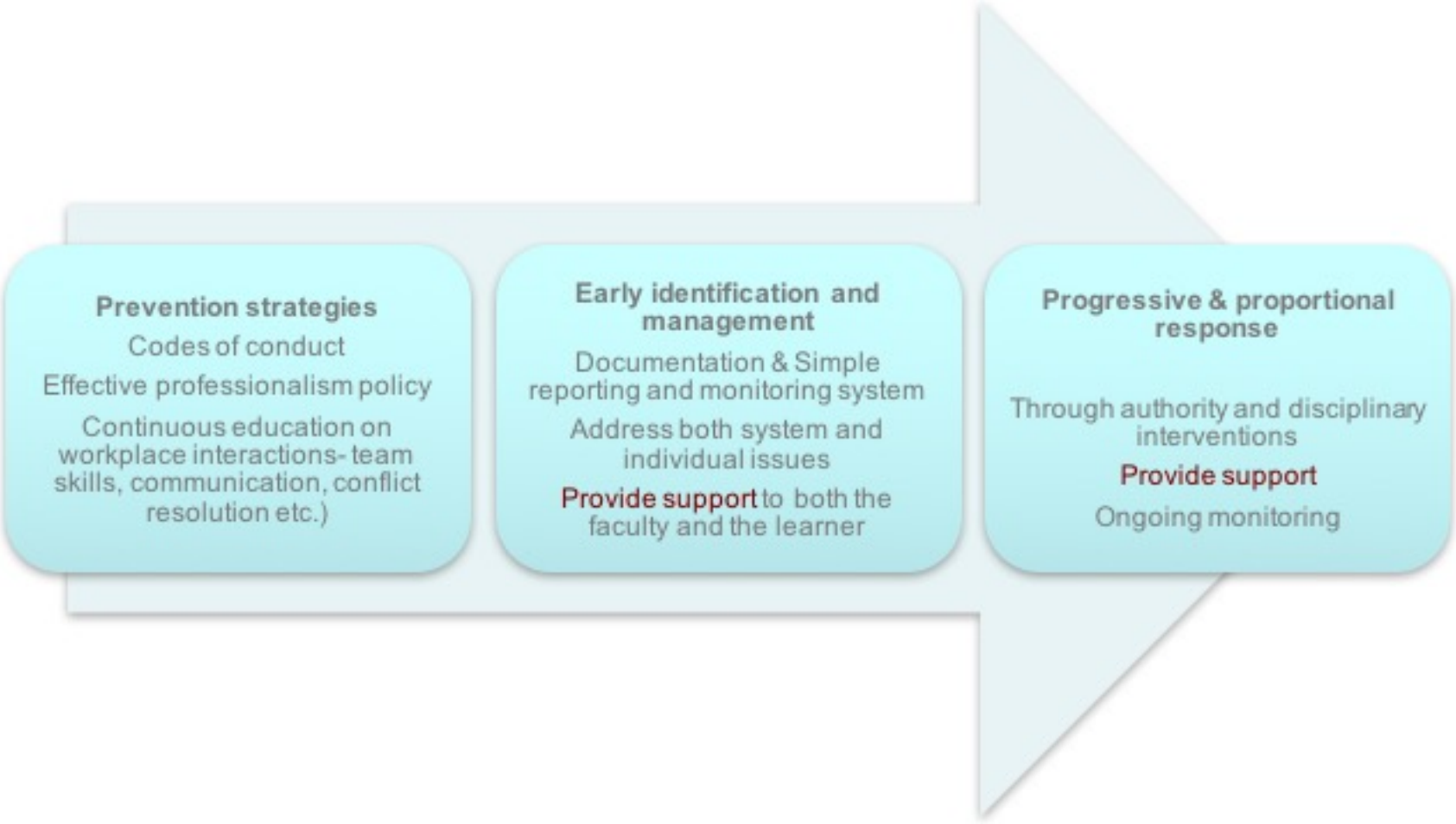
Framework for Diagnosis and Intervention

Document

Assess (& Accommodate ???)

Resolve

Framework for addressing disruptive workplace behavior that adversely impacts the LE



Document –> Assess –> Proportionate intervention-> Monitor

Exploring underlying root causes and Interventions

Be mindful of the context, system and personal issues contributing to disruptive behavior.

Addressing personal issues

- Underlying mental health condition
  - Assessments, if needed, (psychological, psychiatric, neurological, addiction)
- Stress (Financial, family, academic demands)
- Difficulties managing Residency/Life balance
- Little to no exposure working in an employment setting
- Inexperience working with a variety of health care providers

Addressing system issues

- Increased clinical, research academic, and administrative workloads
- Excessive demands in the context of scarce resources
- Faculty shortages
- Insufficient education and training
- Unclear expectations and lack of consequences for disruptive behaviors
- Lack of process or burdensome administrative procedures/under-reporting

Support for Learners and Faculty

- **Counselling programs (Wellness Office, University resources, external physicians and consultants)**
- **Specific supports for managing stresses, anger, work-life balance, etc.**
- **Coaching / Mentoring**
- **Facilitation / Mediation of situations with high conflict**

Case Study: Harassment

- College of Medicine and Health Region coordinate a strategy
- Consulted experts: Human Rights Commission
    a) Firewall between individual and group issues
- Independent, respected faculty leader & experienced hospital mediator engaged
- Met with Division Head and Program Director separately
- Dean met with residents separately
- Dean and CEO met with unit and physicians
- Met with allied health professionals
- All (more or less) committed to six month process

Case Study: Harassment cont'd

- Monthly surveying residents/regular meetings
- Code of conduct developed
- Two mandatory educational sessions
  - Intimidation and harassment
  - Physical wellness
- Mediator engaged with a few
- Dean and CEO regularly updated

Key points

- Learning environment (LE) is critical for optimal learning and safe work.
- There is an overlap between workplace environment and LE in residency due to the primarily service-learning foundation.
- Disruptive behaviors by both the faculty and the learners adversely impact LE.
- Preventive strategies through codes of conduct, ongoing education have a better ROI.
- Addressing disruptive behaviors requires timely identification, determination of root causes, addressing both system- and individual issues and rigorous monitoring.
- Key resources and processes including algorithms are available.

" I will make care safer . . .

. . . by speaking up when I see things that need to be addressed."

- Dr. Gary Groot

Safety Alert/ Stop the Line Initiative
putting the Patient First

Final Word

- Speak truth to power
- Support those that speak truth to power

- Thank you for your time and attention