Summary Task Force Report on UT Southwestern GME Trainees' Ability to Raise Concerns Without Fear

UT Southwestern Medical Center
Graduate Medical Education *Ad Hoc* Task Force on Trainees' Ability to Raise Concerns without Fear
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I. Executive Summary

Within the United States (US) healthcare system, there has been an increasing focus on the importance of burnout and healthcare team well-being at all levels, including in graduate medical education (GME). The Accreditation Council for Graduate Medical Education (ACGME) holds a "commitment to the well-being of residents, faculty members, students, and the healthcare team" as one of its foundational core values and assesses institutions in this domain, including via its annual survey of GME trainees. UT Southwestern GME leadership noted that, from 2011-2019, our institution consistently scored at or below the national mean on the annual ACGME survey regarding "residents' ability to raise concerns without fear of intimidation or retaliation." A multidisciplinary Task Force was created in January 2019 to identify the barriers within the clinical learning environment to trainees raising concerns without fear and to provide recommendations for how to address these concerns at the institutional and program level in a supportive learning environment.

The Task Force members first established a framework for how to understand residents' ability to raise concerns without fear based on three concepts: a culture of psychological safety, the tension between raising concerns without fear and confidentiality, and organizational barriers or promoters of raising concerns without fear. Then, we analyzed primary data from UT Southwestern to understand these barriers including: 1) Aggregate ACGME resident survey data (2011-19); 2) Clinical Learning Environment Review (CLER) site visit reports (2014-19); 3) Undergraduate Medical Education (UME) survey data on learner mistreatment; 4) Internal GME Survey (June 2019); and 5) GME Trainee focus group interviews (November 2019). Key findings from this data review, specifically the internal GME survey, are the following:

- 20% of respondents disagreed/strongly disagreed that they "can raise problems or concerns without fear of intimidation or retaliation" in their program.
- 23% of respondents disagreed/strongly disagreed that they "[are] satisfied with the program's process to deal confidentially with problems or concerns."
- 79% of respondents indicated they were "aware of the procedures for reporting or raising concerns in their program."
- 66% of respondents who experienced or witnessed specific problems or concerning behaviors did not ever report these concerns; of those who did not report, 31% indicated a fear of retaliation or reprisal as a contributing factor in not reporting.
- 24% of respondents reported that their education or clinical care had been compromised by fear of retaliation at some point.

Based on this review, the Task Force has recommended 13 proposed action items for consideration by the GME committee and larger community in the following 5 categories: **Awareness; Reporting Processes; Education; Tracking; and Collaborations**. The Task Force believes that these action steps, if implemented, will provide the necessary roadmap for UT Southwestern to progress in its development of a more supportive and effective learning

climate in furtherance of its goal to maintain its position as a national leader of excellence in medical education and patient care.

II. Introduction: Why this report now?

In 2008, Don Berwick and colleagues proposed the Triple Aim as a mechanism to improve healthcare in the United States (US), with a focus on 3 dimensions of performance: improving population health, enhancing patient care experiences, and reducing per capita cost.[1] While this framework has now permeated the US healthcare landscape, pursuit of this Triple Aim has coincided with a now well-documented epidemic of professional burnout and dissatisfaction among physicians and other members of the healthcare team.[2] Given the growing data that associates high rates of clinician burnout with worse patient health outcomes and lower patient satisfaction, leaders in the field have called for a transition to the Quadruple Aim—**with care team well-being as a prerequisite for achieving the other desired goals in healthcare**.[2] This clarion call has led major organizations like the American Medical Association and the National Academy of Medicine to set as a major priority addressing issues of physician wellness and resilience. In 2017, the National Academy of Medicine launched the Action Collaborative on Clinician Well-Being and Resilience, a network of more than 60 organizations committed to reversing trends in clinician burnout by increasing visibility and awareness of current challenges and advancing evidence-based multidisciplinary solutions.[3] The Accreditation Council for Graduate Medical Education (ACGME), in its role as the leading accrediting and governing board for US graduate medical education (GME), was a sponsoring organization in this collaborative.

The ACGME has consistently held a "commitment to the well-being of residents, faculty members, students, and the healthcare team" as one of its foundational core values.[4] In 2014, the ACGME Board of Directors established a task force to facilitate positive transformational change in four areas of physician well-being across the GME landscape: education, ACGME levers to inform change, research, and collaboration across the medical education continuum.[4] The ACGME has held a series of 5 annual symposiums on Physician Well-Being and featured this topic at its annual education conference. The two most tangible steps that ACGME has taken in this arena include: 1) Revision of the ACGME Common Program Requirements, effective July 1, 2017, to include a dedicated section on the importance of physician well-being in graduate medical education; and 2) Creation of the Clinical Learning Environment Review (CLER) program, a formative assessment program developed to evaluate how institutions are training GME trainees to provide safe, high-quality patient care.[4]

One of the primary methods that the ACGME uses for tracking progress is through serial assessments of individual GME trainees, training programs, and Sponsoring Institutions. The ACGME annually (between January to April each year) conducts a confidential online survey for all GME trainees at an institution, which covers content areas including clinical experience, education and program resources, patient safety, teamwork, professionalism, and trainee well-being. Summary data from these surveys is used to inform decisions regarding accreditation status for individual programs and the Sponsoring Institution. The CLER program involves a multi-day site visit to every Sponsoring Institution roughly every two years, with an in-depth assessment of six CLER focus areas, including well-being and professionalism, followed by formative feedback given to the GME and institutional leadership.[4]

As one of the largest GME programs in the nation, UT Southwestern sponsors over 100 ACGME-accredited residency and fellowship programs, 65 additional Texas Medical Board-approved fellowships, and more than 1,400 residents and fellows in active training. Our mission is to provide world-class training in an individualized environment that emphasizes quality, safety and innovation. Given the national trends described above and the scope of the UT Southwestern GME landscape, the GME leadership has significantly increased its attention and investment in resources to support trainee well-being over the past several years. Most notably, the establishment of the Resident Wellness and Counseling Center, one of the first of its kind, is a resource for confidential assistance for trainees in managing burnout, dealing with mental health conditions, or receiving educational support.

However, during its 2018 annual internal GME institutional review, the UT Southwestern GME leadership identified a concerning trend on the confidential ACGME Resident survey aggregate results, which showed consistently lower scores than the national mean in the area of residents' ability to raise concerns without fear of intimidation or retaliation (**Table 1**). In light of this trend, the Graduate Medical Education Committee (GMEC) determined the creation of an *ad hoc* Task Force was warranted to further investigate the underlying issues and to make recommendations for potential interventions. In January 2019, this Task Force was created under the direction of Dr. James Cutrell with inclusion of a broad representation of faculty, GME trainees, and support staff from across the UT Southwestern GME. This report serves as a summary of the findings and recommendations of the Task Force.

Year	% Program Compliant / % Yes*	Program Mean	% National Compliant / % Yes*	National Mean	% Differential	Mean Differential
2018-2019	81	4.2	82	4.3	-1	-0.1
2017-2018	76	4.1	82	4.2	-6	-0.1
2016-2017	81	4.2	82	4.2	-1	0
2015-2016	79	4.2	81	4.2	-2	0
2014-2015	77	4.1	80	4.2	-3	-0.1
2013-2014	77	4.1	80	4.2	-3	-0.1
2012-2013	79	4.1	81	4.2	-2	-0.1
2011-2012	79	4.1	82	4.2	-3	-0.1

Table 1. Residents' Ability to Raise Concerns Without Fear or Intimidation:
Aggregate UT Southwestern Programs and National ACGME Resident Survey Results, 2011-19

III. Task Force Charter and Membership

A. Mission Statement

The mission of this task force was 1) to investigate and identify the barriers within the clinical learning environment at UT Southwestern to GME trainees raising problems or concerns without fear of intimidation or retaliation; and 2) to recommend institutional and program strategies and best practices that facilitate effective mechanisms for GME trainees' concerns to be raised and addressed in a safe and supportive environment.

B. Goals

1. **Identify and understand the barriers within the clinical learning environment at UT Southwestern to trainees raising concerns without fear of intimidation or retaliation** through various venues including internal surveys, focus group interviews, and engagement of stakeholder groups.

2. **Summarize these findings and draft proposed recommendations for GME in the areas of institutional and program best practices** for reporting, evaluation, and interventions to address resident concerns or mistreatment in a safe clinical learning environment.

3. **Establish dissemination plan for increasing awareness** of reporting and GME intervention processes among UT Southwestern GME trainees and best practices among program leadership for addressing concerns in a supportive learning environment.

C. Timeline of Task Force Activities to-date

Task Force Goal/Deliverable	Timeline
Establish task force and create charter	March 2019
Draft internal survey regarding residents raising concerns without fear	April 2019
Administer survey to UTSW GME trainees	June 2019
Review results with various stakeholders (GMEC, Resident Wellness Committee, etc.)	Summer 2019
Plan and Conduct focus group interviews with various GME trainee groups	August-November 2019
Draft summary report of findings and recommendations for GME reporting processes and interventions for GMEC	December 2019-January 2020
Begin process of dissemination to GME trainees and faculty on findings and new processes	January- March 2020

D. Task Force Membership

Name	Title	Department
Dr. James Cutrell[#]	PD, Infectious Diseases Fellowship	Internal Medicine
Dr. Lindsey Pershern	Residency Associate PD	Psychiatry
Dr. Gail Peterson	PD, Cardiology Fellowship; Residency Associate PD	Internal Medicine
Dr. Jeffrey Chidester*	Resident	Internal Medicine
Dr. Josephine Thinwa*	Fellow, Infectious Diseases	Internal Medicine
Dr. Kareem Abdelfattah	Residency PD	General Surgery
Dr. Dazhe (James) Cao	PD, Medical Toxicology	Emergency Medicine
Dr. Angela Gardner	Teaching Faculty	Emergency Medicine
Dr. Cory Pfeifer	Residency Associate PD	Radiology
Dr. Desi Schiess*	Resident	Radiology
Dr. Alycia Wanat-Hawthorne	Residency Associate PD	Anesthesiology and Pain Management
Dr. Julie Lo	Residency Associate PD	Obstetrics and Gynecology
Dr. Andrew Yu	Residency Associate PD	Pediatrics
Dr. Aarusha (Jana) Das*	Chief Resident	Pediatrics
Dr. Kaleena Patel*	Chief Resident	Pediatrics
Ms. Diana Davila	Program Coordinator	Family Medicine
Ms. Megan Ping	Program Support Staff	GME Office

Task Force chair; * GME trainee or chief resident; PD- Program Director

IV. Conceptual Framework: GME Trainees' Ability to Raise Concerns

The first task of the task force was to establish a shared conceptual framework amongst its members for understanding the ability of GME trainees to raise concerns without fear of intimidation or retaliation. This framework began with considering the important role of the clinical learning and working environment and its intersection with and impact on the well-being of all members of the health care team, including GME trainees and faculty members.

A. ACGME Common Program Requirements for the Learning and Working Environment

A natural starting point for considering the intersection of physician well-being, professionalism, and the clinical learning environment was the ACGME Common Program Requirements, which serve as the governing principles and accreditation standards for GME in the United States.[5] As mentioned in the introduction, since 2017, the ACGME has explicitly expanded its focus to physician well-being and the clinical learning environment beyond the prior, more restricted focus on duty work hour restrictions. The current requirements, in effect since July 2019, mandate that medical education should occur "in a learning and working environment which emphasizes four cardinal principles:

- Excellence in safety and quality of care rendered to patients by residents today
- Excellence in safety and quality of care rendered to patients by today's residents in their future practice
- Excellence in professionalism through faculty modeling
- Commitment to the well-being of the students, residents, faculty members, and all members of the healthcare team."[5]

The unifying message of these goals is the recognition that professionalism and a commitment to healthcare team members' well-being are essential to achieving the goals of safe and high quality care for patients. The pursuit of these goals is also considered a shared responsibility between individuals as well as the training programs and Sponsoring Institutions. Specifically, "programs, in partnership with their Sponsoring Institutions, have the same responsibility to address well-being as to other aspects of resident competence. Physicians and all members of the healthcare team share responsibility for the well-being of each other."[5]

With regards to the clinical learning environment, GME programs, in partnership with their Sponsoring Institutions, are mandated to provide: 1) "a professional, equitable, respectful, and civil environment that is free from discrimination, sexual and other forms of harassment, mistreatment, abuse, or coercion, of students, residents, faculty and staff"; and 2) "a process for education of residents and faculty regarding unprofessional behavior and a confidential process for reporting, investigating, and addressing such concerns."[5] In the absence of this safe and supportive learning environment, physician well-being, patient safety, and quality of care may be jeopardized.

In order to assess whether programs are providing this type of learning environment, the annual ACGME resident survey confidentially surveys all GME trainees on whether they are "able to raise concerns without fear or intimidation." The survey also includes questions on related topics of whether residents are "satisfied with the process for addressing problems and concerns" and whether a "process is in place for confidential reporting of unprofessional behavior." Although what constitutes fear of intimidation or retaliation is not explicitly defined in the ACGME requirements or survey, medical literature on the topic highlights negative consequences for raising concerns such as verbal abuse or other forms of shaming or harassment, removal of privileges or additional work assigned as "punishment", unwarranted negative evaluations, or discrimination in career advancement, as examples.[6]

B. A Culture of Psychological Safety

An important related concept to the ability to raise concerns without fear is **psychological safety.** It has been broadly defined as "a climate in which people are comfortable expressing and being themselves."[7] When applied to a group or team, it is "the shared belief that the team is safe for interpersonal risk taking."[8] Harvard Business School Professor Dr. Amy Edmondson, a pioneer in applying the concept of psychological safety to organizational leadership, summarizes it as a "belief that one will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes." Psychological safety has also been linked to the related concept of speaking up or employee "voice," the specific behavior of upward-directed communication to challenge the status quo and offer ideas to improve processes in an organization.[9]

A culture of psychological safety has been identified as an important mediator of organizational and team success across a wide range of industries. For example, Google's Project Aristotle, a seminal two-year study of 180 teams to identify the most important ingredients for a highly effective team, found **psychological safety to be the most important predictor of team effectiveness**.[10] Dr. Edmondson and her colleagues have similarly found psychological safety impacts team dynamics in the fields of medicine and education.[11] Paradoxically, in an evaluation of medical error reporting within eight hospital units, high-functioning teams with supportive leadership and expectations of excellence had higher rates of errors reported. This finding was not because these teams were committing more errors, but rather because they were more willing to disclose, discuss, and learn from their mistakes rather than hiding concerns out of fear.[12]

Unfortunately, several well-entrenched professional norms within medicine may impede the development of psychological safety by inadvertently creating barriers to speaking up or asking for help.[11] First, rigid hierarchy and status differentials, as sometimes encountered in academic medicine, can prevent speaking up about concerns and contribute to medical errors. Second, the norm of provider autonomy in medicine can create a culture of non-interference with colleagues' practice patterns, impeding improvement and adoption of best practices. Finally, according to Dr. Edmondson, "the perceived need for impression management to protect one's professional image is extremely high in medicine,"[12] working against the necessary transparency and vulnerability to disclose errors or concerns. Although acculturation into these professional norms

occur early in medical training, specific attitudes and behaviors on the part of the organizational leadership can mitigate their negative impact on psychological safety. Specifically, leader inclusiveness—words and deeds that invite and appreciate others' contributions—and leader willingness to acknowledge their own gaps in knowledge and need for help are key promoters of psychological safety and team effectiveness for the rest of the healthcare team.[13,14]

C. Tension Between Raising Concerns Without Fear and Confidentiality

A second important component of our conceptual framework was to **acknowledge and examine the apparent tension between two ACGME survey question topics: raising concerns without fear and confidential reporting**. On the one hand, the survey questions trainees about their ability to raise concerns without fear of intimidation or retaliation, as already discussed. On the other hand, the survey asks whether trainees are satisfied with the program's process to deal confidentially with problems or concerns. Presumably, the requirement for confidential reporting mechanisms is intended as both a means to encourage openness and transparency in reporting concerns and to reduce fear of intimidation or retaliation for those who report concerns. However, the coexistence of these two mandates introduces an apparent contradiction.

As pointed out in a recent editorial in *Academic Psychiatry* by Dr. Michael Shapiro, "the order to allow residents to raise concerns without fear of retaliation is the order that residents are not to be harmed, to diminish danger.[15] But the order to protect confidentiality would only be necessary if there is a risk of danger, so the confidentiality mandate itself implies danger. Why would we have to protect trainees' confidentiality in raising concerns, if there should be no harm or danger in raising concerns?" Indeed, Shapiro suggests that the emphasis on confidentiality, by teaching residents and faculty to avoid addressing concerns or unprofessional behavior directly, may inadvertently lead to increased anxiety and make trainees less confident that programs take their concerns seriously or make significant changes in response to them. Additionally, the methods employed to ensure confidentiality of reporting can hinder the timeliness and effectiveness of faculty feedback and limit the ability of program leadership to investigate and address fully the concerns raised. Finally, an emphasis on strict confidentiality of reporting may be counterproductive to the development of a true culture of psychological safety within an organization.

At present, the tension between these two mandates cannot be fully resolved unless the ACGME alters its program requirements and survey questions regarding confidential reporting. Legitimate arguments can be made that there are scenarios where the benefits of confidential reporting or even non-reporting outweigh the attendant risks, for example, in Title IX-related concerns or in the context of a counselor-client or doctor-patient relationship. However, in other cases, reliance on confidential reporting to reduce fear of intimidation or retaliation is an inadequate substitute for the more difficult work of creating processes and a learning climate where trainees feel safe and supported to raise concerns openly. The pursuit of a culture of psychological safety should lead to decreased fear of retaliation and actual incidents of unprofessionalism or mistreatment while lessening the situations where confidential reporting is necessary.

D. Organizational Barriers and Opportunities to Raising Concerns

The final component of our conceptual framework considers **the organizational characteristics that can either promote or inhibit residents from speaking up with their concerns**. In this regard, a recent qualitative interview study by Voogt et al. assessing the organizational barriers and opportunities for Dutch medical residents speaking up is instructive.[16] Although the primary context of the study was residents' willingness to speak up with their ideas for quality improvement in frontline care delivery, the principles can equally be applied to residents' willingness to speak up with concerns related to unprofessional behavior or mistreatment. The authors highlight two major considerations that contribute to the cost-benefit analysis of whether or not residents choose to speak up: **efficacy calculus** (*Is it effective to speak up?)* and **safety calculus** (*Is it safe to speak up?).*[16] Helpfully, the authors were able to identify organizational or program-specific factors that effectively serve as either inhibitors or drivers for the efficacy calculus or safety calculus (**Table 2**). Inhibitors of "speaking up" included perceived or prior negative experiences or a lack of personal resources or knowledge for how to raise concerns; promoters of "speaking up" included supervisors and organizational structures that proactively invite feedback and suggestions as well as positive experiences or examples of feedback resulting in change. Finally, they conclude with a series of five recommendations for how organizations can empower residents to speak up or have a "voice" to improve the quality of care, many of which mirror or dovetail with the preceding discussion of a culture of psychological safety.[16] These recommendations include:

- Actively invite residents to provide input or engage in organizational change.
- Develop an open attitude toward residents' suggestions.
- Invite residents to meetings in which managerial issues are discussed.
- Do not automatically expect the resident who speaks up should be the one that fixes the problem.
- Create short lines of communication.

Adaptation of the concepts of efficacy calculus and safety calculus provides a useful practical tool for understanding the ability of our residents to raise concerns without fear and for considering the organizational or program factors at UT Southwestern that inhibit or promote residents speaking up with their concerns. Additionally, the recommendations for resident empowerment provide tangible examples of potential interventions to encourage residents' voice.

	Efficacy Calculus "Is it effective to speak up?"	Safety Calculus "Is it safe to speak up?"
Inhibitors	• Short clinical rotations • Lack of personal resources (time and/or energy) • Seeing no alternatives • Negative experience (personal or vicarious) • Socialization ("Things never change around here") • Lack of overview (not knowing who to contact or where to begin)	• Belief that speaking up is the same as complaining (desire to maintain a hard-working resident image) • Perceived negative influence on job opportunities (troublemaker label) • Perceived negative influence on colleagues • Negative experience (personal or vicarious) with speaking up
Drivers	• Small teams, compact organization • Strong network (know who to contact) • Joint meetings with medical and nonmedical staff • Being invited to share a suggestion or join an existing project • Positive experiences (seeing things actually can change)	• Supervisor with open, proactive attitude • Nonhierarchical organization • Work experience (learning that there are alternative solutions, gaining confidence in one's own ideas) • A strong case (objective evidence) • Support from colleagues

Table 2. Inhibitors and Drivers Influencing Whether Medical Residents Speak Up About Organizational Barriers and Opportunities to Improve Quality of Care (Adapted from ref. 16)

V. Primary Data: Identifying and Understanding Barriers at UT Southwestern

In the context of the above conceptual framework, the task force commenced work on its first goal: **to identify and understand the barriers within the clinical learning environment at UT Southwestern to trainees raising concerns without fear of intimidation or retaliation.** In order to achieve this goal, the task force members determined that both quantitative and qualitative data from across the spectrum of GME programs would be important, supplemented by insights from the diverse members on the task force and other stakeholders. The primary data sources, which will be summarized below, included: Aggregate UT Southwestern ACGME Resident Survey Data; UT Southwestern CLER Site Visit Data; Undergraduate Medical Education (UME) Survey Data on Learner Environment and Student Mistreatment; UT Southwestern Internal GME Survey Data; GME Trainee Focus Group Interviews.

A. Aggregate UT Southwestern ACGME Resident Survey Data

The first set of primary data reviewed was the ACGME Resident Survey aggregate data for all UT Southwestern programs from the periods spanning the academic years 2011-2012 through 2018-2019. As mentioned previously, this data demonstrated that, over this period of time, UT Southwestern GME programs in aggregate consistently scored lower than the national mean in the area of residents' ability to raise concerns without fear of intimidation or retaliation (**Table 1)**. The average % program compliance at UT Southwestern across this eight year period was 77% whereas the average % program compliance nationally over the same period was 81%. Although there was heterogeneity with regards to compliance across the individual GME programs at UT Southwestern, overall the differential of - 4% with compliance in this area was in distinction to most other areas where UT Southwestern programs meet or exceed the national mean. The ACGME survey does not delve deeper to identify the underlying issues or sources of fear in reporting. **Nevertheless, this consistent trend was considered a signal that warranted further investigation to inform improvements to the clinical learning environment and to avoid jeopardizing future accreditation status for individual programs or the Sponsoring Institution.**

A few comments regarding methodology of the ACGME Resident Survey are necessary. The survey is administered confidentially and electronically to all GME trainees every year between the periods of January to April (individual programs typically have approximately a 1 month window during this period of time). Programs are mandated to have at least 70% of their trainees complete this survey so response rates are consistently high. This particular question regarding whether "residents/fellows can raise problems of concerns without intimidation or retaliation" is answered on a 5-point Likert scale (Strongly agree, Agree, Neutral, Disagree, Strongly disagree). The ACGME has defined what is meant by the various terms in supplementary documents, although these definitions are not listed within the actual survey. **Depending on the question, responses in the 'Neutral' category or lower may be considered as noncompliant answers.** Based on the individual trainee responses, aggregate program and institution compliance rates are calculated. Programs and institutions do not receive individual level data but only aggregated response rates. For programs with less than 4 residents/fellows, the response rate required is 100%, and smaller programs receive multi-year aggregated reports to maintain confidentiality.

B. UT Southwestern CLER Site Visit Data: 2016 Parkland Hospital CLER Visit Report

The second set of primary data which the Task Force considered was the CLER site visit data from prior institutional visits. At the time of the Task Force creation, UT Southwestern had received 2 prior CLER visits, both at the Parkland Health and Hospital System training site in 2014 and 2016. As mentioned above, the CLER site visit is a multi-day site visit to training institutions that focuses on six core areas, two of which are well-being and professionalism. The team of CLER Field Representatives meet with executive leadership of the organization; organizational leadership in patient safety, health care quality, and well-being; leaders of GME; and focus groups of residents, fellows, faculty members, and program directors. Additionally, they conduct rounds on patient floors, units, or service areas to gather input from a broader range of clinical staff and to observe firsthand how the organization functions as a clinical learning environment. At the conclusion of the visit, the CLER visit team verbally shares formative feedback and observations in the six CLER focus areas with the organizational and GME leadership, followed by a written summative report. **Given the breadth of observations and interviews done during a CLER visit, these reports are a rich source of insight into the clinical learning environment at our institution**, with the caveat that the visits so far have focused on only one training site, Parkland Hospital.

In reviewing the 2016 Parkland CLER visit report, the Task Force focused on observations or data that covered areas directly or indirectly related to residents' ability to report concerns or medical errors in a safe, supportive environment. The following responses from the resident/fellow focus group interviews are representative of this data.

2016 Parkland CLER Visit Resident/Fellow Interview Questions	% Answered Yes
B1. Percentage of residents/fellows who reported experiencing an adverse event, near miss/close call, or unsafe condition.	81%
B2. Percentage who reported this event through the clinical site's reporting system.	36%
B24. Percentage of residents/fellows who reported that their clinical site provided a supportive, non-punitive environment for coming forward with concerns regarding honesty in reporting (e.g. patient data, duty hours).	98%
B26. Percentage of residents and fellows reported having felt pressure to compromise honesty or integrity to satisfy an authority figure during their training at clinical site.	7%
Hypothetical scenario of being asked to include Department Chair on manuscript he/she did not write: 34% stated they would advise colleague to include Chair on paper.	

Additionally, the Task Force noted that the qualitative comments from the summative report highlighted the prevalence and impact that physician burnout among residents, fellows, and faculty had on their professional growth and the clinical learning environment. For example, "the residents and fellows described observing signs of depersonalization, emotional exhaustion, and

a sense of low personal accomplishment in their colleagues. **Some of the residents and fellows expressed the belief that burnout is prevalent among residents and fellows, and is unavoidable.**" When asked about physician burnout among faculty and program directors, "**residents and fellows described observing changes in their moods, a lack of enthusiasm for teaching and patient care, and complaints about the work ethic of the residents and fellows**." While these reports of physician burnout among trainees and faculty members are not unique to UT Southwestern as outlined in the introduction, the Task Force wanted to highlight the negative downstream consequences that physician burnout among trainees and faculty can have on the clinical learning environment and the culture of psychological safety needed to encourage trainees to speak up with their concerns.

C. UME Survey Data on Learner Environment and Student Mistreatment

The third set of primary data reviewed by the Task Force was the UT Southwestern UME internal survey data on learner environment and student mistreatment. In preparation for its Liaison Committee on Medical Education (LCME) accreditation visit (the UME equivalent of the ACGME), the UT Southwestern Office of Student Affairs conducted an extensive review of the learner environment and student mistreatment as required by LCME standards. One of the major data sources for the LCME accreditation visit is the annual Graduate Questionnaire (GQ), which all graduating medical students complete. The GQ has several questions about the prevalence, frequency and types of student mistreatment experienced, including public humiliation, harassment, discrimination on the basis of sex, gender or sexual orientation, and other types of offensive behavior. It also asks students if they are aware of the institutional policies regarding student mistreatment and the reporting mechanisms for such incidents.

Since 2015, based on concerns regarding student mistreatment in the learning environment, the UT Southwestern Office of Student Affairs has been conducting annual internal surveys of all medical students during their clinical training years to identify the types and sources of student mistreatment and have implemented several strategies to raise awareness about reporting these concerns. **While it is outside the scope of our Task Force or this report to review the UME data, these data provide an important window into the perspective of our students who share an overlapping clinical learning environment with our GME trainees**. Dr. Angela Mihalic, Dean of Medical Students and Associate Dean of Student Affairs, presented data on the UME work on the learner environment and student mistreatment concerns at UT Southwestern to our Task Force. This presentation was invaluable for our Task Force in regards to both development of an internal GME survey tool and consideration of potential barriers to reporting and interventions. A summary of some of the "lessons learned" from the UT Southwestern UME experience with relevance to the GME include the following:

- The value of internal, serial, longitudinal survey data to identify problems of unprofessional behavior or mistreatment of learners and to track changes over time was clearly proven.

- The ability of sustained leadership engagement to increase awareness of policies and reporting mechanisms for concerns was demonstrated although reporting rates may remain low despite increased awareness.
- Unprofessional behavior or mistreatment directed at learners remains a concern across the clinical learning environment and span the gamut of behaviors, including those which would be considered forms of intimidation or harassment.
- Given the interconnectedness of UME and GME learners and the supervising faculty, modeling and conduct of unprofessional behavior or mistreatment can occur "bidirectionally" across the clinical learning environment.
- Despite a tendency toward siloed efforts, overlapping professionalism and well-being concerns in the UME and GME space create opportunities for collaborative interventions to address the learning environment more globally.

D. UT Southwestern Internal GME Survey Data

The fourth set of primary data reviewed by the Task Force was a newly created internal GME survey to specifically address the topics germane to our goals. Based on the UME experience reviewed above and our own discussions, the Task Force believed that it was imperative to obtain a more detailed and comprehensive understanding of the learning climate at UT Southwestern from the perspective of GME trainees than what was offered in the limited questions from the ACGME survey. Therefore, over the course of two months, the Task Force developed a 12-question survey to investigate the learning climate with regards to the ability to raise concerns without fear, awareness of reporting procedures, types and sources of unprofessional behavior or mistreatment, frequency of reporting and reasons for non-reporting. The complete survey instrument is included as **Appendix 1** in this report. The survey was distributed via email to all GME trainees for confidential and anonymous completion through Survey Monkey©; however, it explicitly stated that it was not intended to replace regular reporting mechanisms already in place. Optional questions regarding demographics such as gender, ethnicity, and level of training were included to determine how representative the responding sample was compared to the overall GME population at UT Southwestern.

The survey was distributed and open for responses during the first three weeks of June 2019. A total of 293 responses were completed, which represented roughly 20% of the total GME population. The demographics for the respondents who answered these optional questions were as follows: Gender (out of 150 respondents): 58% female; Ethnicity (out of 116 respondents): African American/Black 6%, Asian 9%, Caucasian/White 66%, Latinx/Hispanic 13%, Other 4%; PGY Level (out of 149 respondents): PGY1 16%, PGY2 18%, PGY3 10%, PGY4 25%, PGY5 or above 28%. Representative survey results and comments are discussed below while more complete survey results are included in **Appendix 2**.

Regarding the statement "In my program, I can raise problems or concerns without fear of intimidation or retaliation," 67% of respondents indicated strongly agree or agree. Additionally, 79% of respondents indicated they were aware of the procedures for reporting or raising

concerns within their training program. The results for questions about ability to raise concerns, satisfaction with the process to deal with concerns, and general respect within the work environment are shown below.

Survey Question	SA	A	N	D	SD
1. In my program, I can raise problems or concerns without fear of intimidation or retaliation.	29%	38%	13%	14%	6%
3. I am satisfied with my program's process to deal confidentially with problems or concerns I might have.	24%	35%	18%	15%	8%
4. Overall , my attendings have treated me with respect.	40%	46%	9%	5%	0%
5. Overall, my fellow trainees have treated me with respect.	52%	36%	7%	3%	1%
6. Overall, other clinical staff have treated me with respect.	33%	45%	13%	5%	3%

SA: Strongly Agree, A: Agree, N: Neutral, D: Disagree, SD: Strongly Disagree

For those who reported experiencing or observing certain negative behaviors during their training, the most frequently observed behaviors were the following, in order (based on weighted average using a 5-point Likert scale from 1=Never to 5=Very often):

- Unresolved interpersonal conflicts leading to a hostile work environment (weighted average 2.14);
- Inability to transition care or find backup when too fatigued to work (weighted average 2.02);
- Unprofessional behavior or mistreatment (e.g. physical threat, sexual harassment, offensive remarks based on gender/race/religion/sexual orientation) (weighted average 1.82);
- Pressure to exceed or underreport duty hours (weighted average 1.81)

With regards to the sources of the negative behaviors, faculty and other residents/fellows were the most common sources although this varied by the type of behavior (see Appendix 2 for full details). For example, patients were the second more frequent source of unprofessional behavior or mistreatment, such as physical threats, harassment, or offensive remarks. Other staff (e.g. nurses, techs, other support staff) were also a common source of unresolved interpersonal conflict leading to a hostile work environment or discouragement from reporting patient safety concerns.

With regards to reporting the above incidents, 66% of respondents indicated that they never report these events. For those who do report, the most common recipients of the reports were either the program director (about 50%) or chief residents or other attendings. Few indicated that they would report to the department chair or a hospital reporting system. For those who did report, 35% were satisfied with the response following the report, while 28% reported being unsatisfied and 37% chose other (and provided free text comments). The most frequent reasons cited for not reporting an event included: "I did not think anything would be done about it," 48%; "The incident did not seem important enough to report," 43%; "Fear of reprisal or retaliation," 32%.

Across all respondents, 24% indicated that their education or clinical care had been compromised by fear of retaliation. Within that group, the most common source of fear of retaliation were attending faculty (64%) and other specified individuals (37%), which included nursing staff, department or hospital administrators, or program directors.

The survey results also included over 200 written comments to various questions, which supplemented the quantitative data. Although it is difficult to summarize all of these comments, a few recurrent themes emerged as demonstrated by the following representative quotes:

- "The times where an event has been reported with no subsequent action creates an environment where residents are held to a different professional standard than faculty."
- "It is difficult to bring up when we feel that interpersonal issues are affecting the work environment—I feel that most of these issues are secondary to burnout."
- "Nothing ever changes in programs when residents raise concerns."
- "I felt that reporting an issue might reflect poorly on myself and cause more problems than if left unreported."
- "Regarding issues with nurses, fear of retaliation and being told by others that reporting would lead to retaliation and more difficulty in patient care."
- "Harassment from patients is very common place and largely something too frequent to report on a case by case basis."
- "I think that our curriculum and work environment fail to make progress because residents don't feel confident that they can voice concerns to administration without some fear of reprisal."
- "House staff meetings to raise concerns should be mandatory."
- "If there is a mechanism in place for us to report concerns or unprofessional behavior of our attendings apart from discussing with our program director, this has not been well explained to us."
- "It needs to be more clear how to report problems with the program director; we are instructed to report problems to our program director but the problem is the program director."
- "It is impossible in a small program to bring up problems without everyone knowing that you are the one making a complaint."
- "Many of the issues raised by this survey come down to a general culture of UTSW. Compared to other medical centers, the emphasis is more on productivity than education, camaraderie, and personal connections with patients. Everyone here is spread so thin and stress to take time to do things and treat people the right way."

There were also several positive comments about examples of program directors or specific programs being proactive about addressing concerns raised and resolving them without fear of retaliation, which were viewed positively by the residents.

It is important to put into perspective and compare the results from the internal GME survey with those obtained from the ACGME Resident Survey. For example, on the internal GME survey question "In my program, I can raise problems or concerns without fear of intimidation or

retaliation," 67% of respondents indicated strongly agree or agree. On the most recent ACGME Resident Survey, the same question was answered in the compliant range (strongly agree or agree) by 81% of respondent residents. The possible explanations for this discrepancy illustrate the strengths and weaknesses or potential biases in each survey. On the one hand, residents may feel more pressure to respond favorably on the ACGME Resident Survey due to concerns about implications for their program's accreditation status. This would lead to a more accurate measure on the internal survey, which also clearly provides more information and granularity on this topic. On the other hand, the internal GME survey was completed by a smaller sample size (293 residents) and may be less reflective of the overall GME trainee population. Specifically, there may be a selection bias where residents who responded to the internal GME survey were more likely to have had negative experiences with reporting concerns or who are dissatisfied with the process for addressing concerns. These differences and potential biases must be accounted for in the interpretation and comparison of the two surveys' data.

E. GME Trainee Focus Group Interviews

The fifth and final primary data set reviewed by the Task Force were the results of UT Southwestern GME trainee focus group interviews. These focus groups were hosted to augment the results of the internal GME survey results and to solicit feedback directly from trainees regarding how current processes to handle concerns were working and what improvements they would like to see. In an attempt to maintain a safe and confidential venue for honest feedback, these focus group interviews were hosted at a campus location removed from the clinical work environment. In order to have a neutral party outside of GME to conduct the interviews, the expertise and experience of Dr. Suzanne Farmer and her team in the UT Southwestern Department of Organizational Development and Training was utilized. Two senior consultants in this department, Kathy Murphy and Randy Hamrick, led a series of six focus group interviews over the course of November 2019.

A full report of the questions and major themes reported in the interviews, de-identified of any personal information, are included in **Appendix 3** of this report. A summary of the themes identified from these focus group interviews is as follows:

- Similar to the results from the internal survey, most residents indicated that the Program Director or Chief Residents were their primary means for reporting concerns. Residents were generally either unaware or more hesitant to use other reporting mechanisms such as the hospital reporting systems, anonymous reporting via MedHub or escalation to the GME or departmental level.
- Trainees believed that concerns reported to the Program Director or Chief Residents, which were within their capacity to address, were typically resolved quickly with closed-loop communication back to the residents about what was done. However, for issues at the hospital level or beyond the capacity of the Program Director to address, much less progress towards a resolution or communication back to the residents occurred.

- Programs which have regularly scheduled meetings to proactively solicit reporting or which have a designated faculty or support staff to serve as a representative for resident concerns were viewed favorably.
- Some confusion and misinformation exists regarding how ACGME resident survey results may affect the accreditation status for the program, contributing to intimidation or fear about honest reporting on the part of residents.
- Although most residents did not report fear of retaliation, there were clear examples of various forms of professional misconduct or retaliatory action directed toward trainees, similar to what was reported on the internal survey.
- The major concerns with reporting in MedHub surrounded either pressure to not document duty hours outside of scheduled time or concerns about breaches in confidentiality of faculty evaluations.
- Major suggestions for improvements included education for trainees on the ACGME resident survey, hospital reporting systems, and UTSW GME structure; training for Program Directors and Chief Residents on how to receive and address concerns more effectively; and more openness on the part of program to new ideas and culture change.

Based on the data and analysis reviewed in section V, the Task Force members were able to achieve goal 1 to **identify and understand the barriers within the clinical learning environment at UT Southwestern to trainees raising concerns without fear of intimidation or retaliation.** This data analysis prepared the Task Force members to then move to goal 2 of summarizing these findings and drafting proposed recommendations for GME in the areas of institutional and program best practices for reporting, evaluation, and interventions to address resident concerns or mistreatment in a safe clinical learning environment.

VI. Task Force Recommendations for GME

In this section, the Task Force will present its proposed recommendations for GME in the areas of institutional and program best practices for reporting, evaluation, and interventions to address resident concerns or mistreatment in a safe clinical learning environment. These recommendations will need to be weighed carefully and implemented as deemed appropriate by the GME Committee and Leadership as well as other stakeholder groups. The Task Force also believes that the findings of this report and recommendations should be disseminated and form a touchstone for the larger GME community as it continues its conversations and action steps to address these important topics. Finally, because this Task Force was an *ad hoc* time-limited group to address a specific mandate, the ongoing work of implementation and tracking progress toward these recommendations will be the responsibility of the various relevant GME committees and subcommittees, individual programs, as well as the broader UT Southwestern community.

The Task Force will present its proposed recommendations in 5 categories, with specific action steps in each category followed by commentary. The 5 categories of recommendations are the following: **Awareness, Reporting Processes, Education, Tracking, and Collaborations**.

A. Awareness

Awareness: Proposed Action Steps
1. The Task Force report findings and recommendations should be broadly disseminated across the UT Southwestern GME community. This can occur through both electronic means as well as, when possible, in-person presentation to key stakeholders by members of the Task Force or GME.
2. The new Title IX legislation (Texas Senate Bill 212) and reporting requirements should be clearly communicated to all current GME trainees, as well as annually during orientation for new GME trainees. Although trainees are not required to report under this law or UTSW policy, they are very strongly encouraged to report Title IX incidents.
3. Available institutional resources to address resident wellness concerns or burnout should be clearly advertised for both prospective and current GME trainees. These resources include the Resident Wellness and Counseling Center, the Parkland Committee on Practitioner Peer Review and Assistance (COPPRA), and others.

Commentary:

The first step to addressing these issues effectively is an open dialogue and awareness by members of the GME community of the current landscape and status of residents' ability to raise concerns without fear as well as resident wellness. Dissemination of this report and recommendations can hopefully help provide awareness and shed light on this discussion. Related to reporting of harassment or mistreatment, new Texas legislation which went into effect January 1, 2020 related to Title IX (Texas Senate Bill 212) has dramatically changed the reporting requirements and penalties for not reporting Title IX violations. Although students

and residents are not considered UT Southwestern employees required to report for the purposes of the new legislation, they are very strongly encouraged to report incidents to a Title IX coordinator. This new legislation may also impact in significant ways the reporting requirements of faculty to whom residents may disclose potential Title IX violations. Finally, while many institutional resources already exist to address resident wellness, burnout or other concerns that residents have, awareness of these resources and how to access them remain inconsistent across the institution.

B. Reporting Processes

Reporting Processes: Proposed Action Steps
4. The Task Force recommends the creation of a centralized webpage on the GME website that serves as an updated clearinghouse for reporting concerns by residents. This webpage should include: • **Clear guidance on where to direct different types of concerns at UT Southwestern and instructions on how to report.** • **Updated contact information or links for reporting to GME, Title IX officers, hospital reporting systems, and other entities.** • **Electronic reporting web form that can be completed confidentially and submitted directly to the GME office.**
5. Once created, a link to this centralized webpage may be embedded in multiple sites including but not limited to the resident evaluations, Fuel Gauge assessments, and the MedHub resident homepage to ensure awareness and easy accessibility.

Commentary:
As the internal survey data and focus group interviews demonstrated, not all GME trainees are aware of the reporting mechanisms at UT Southwestern. The Task Force members believed that the current reporting systems may be hard to understand, find or navigate. Additionally, for issues related to Program Directors or in smaller programs, or those related to recurrent issues that require escalation, many residents were not clear on how to report. A single, up-to-date centralized webpage maintained by the GME office with clear instructions and information on where and how to report concerns was deemed to be the preferred mechanism. Ideally, this would also include a confidential electronic web form that can be directly submitted, similar to what UME has implemented. Once the webpage is created, inclusion of a link to it could be embedded in multiple locations to direct residents' reporting of concerns to the proper channels.

C. Education

Education: Proposed Action Steps
6. Education should be provided to all current GME trainees and at least annually on the following topics: Reporting processes for raising concerns (see action step 4 and 5), UT Southwestern GME organizational structure and personnel, and ACGME Resident Survey content and its role in program accreditation decisions. This education may be provided

through a combination of electronic training modules as well as GME information materials or presentations during orientation or disseminated through individual programs.
7. Education and training should be provided to all current Program Directors, Program Coordinators and Chief Residents and at least annually on the following topics: How to handle and address resident concerns effectively, and best practices (see commentary below) on creating a culture of safe reporting. This education may be provided through a combination of electronic training modules as well as in-person presentations as part of ongoing Program Director and Program Coordinator development seminars or new Chief Resident orientation.

Commentary:
The internal survey data and focus group interviews demonstrate clear knowledge gaps on the part of at least some GME trainees in several key areas: the reporting processes for raising concerns, the function of UT Southwestern GME and how that works for non-UT employed trainees, and the role of the ACGME Resident Survey in accreditation decisions. These gaps can be addressed with education, but will require ongoing maintenance education as new residents start each year.

The data also clearly demonstrate that a specific program's leadership team (Program Director, Program Coordinator, Chief Residents, etc.) plays a pivotal role in modeling and establishing a culture of appropriate and effective handling of residents' concerns. Therefore, faculty development for these leaders on how to effectively handle and address resident concerns should be provided in the form of a GME seminar, with enduring content that can be reviewed. Also, programs should be encouraged to implement institutional best practices identified to assist in creating a culture of safe reporting such as regular venues where trainees are invited to raise concerns, timely feedback to residents on how concerns are being addressed or resolved, and mechanisms for tracking resident burnout and concerns regarding wellness.

D. Tracking

Tracking: Proposed Action Steps
8. The GMEC should continue to track aggregate ACGME Resident Survey data to monitor trends in residents' ability to raise concerns without fear. However, possible changes to the questions on the ACGME Resident survey may make longitudinal comparisons over time more challenging.
9. An internal GME survey, similar to the one conducted by this Task Force, should be done annually to survey residents' ability to raise concerns without fear and related issues of mistreatment or unprofessional behavior. This internal survey can be delivered electronically to all GME trainees using the same question format to track trends and progress over time.
10. The Program Performance subcommittee of GME may consider adding a specific metric to the program performance dashboard (PPD) to track compliance with the ACGME

requirement regarding residents' ability to raise concerns without fear. The PPD highlights particular areas for programs and GME to focus improvement efforts.

Commentary:
Successful improvement of performance in any area requires continual measurement and tracking of progress over time. In this regard, the GMEC should continue to track aggregate ACGME Resident Survey data for trends in residents' ability to raise concerns without fear. This survey remains the tool that captures the highest percentage of our GME trainees every year and is the basis for accreditation decisions. However, based on available information on the ACGME website, the wording and topics of the resident survey may be undergoing revision, which could create challenges in making longitudinal comparisons. Based on the positive experience with the UME since 2015 and the Task Force's use of an internal survey for its work, we believe that conducting an annual internal GME survey, using similar questions to those used in our survey, would provide meaningful data and trends to evaluate the impact of interventions and to supplement what is collected on the ACGME Resident Survey. Additionally, the program performance dashboard may be a tool where ACGME compliance on this topic could be tracked at the program level to allow targeted GME assistance and support to individual programs.

E. Collaborations

Collaborations: Proposed Action Steps
11. Hospital GME leadership at each of the training sites should be briefed on this report and engaged on how ongoing hospital efforts to improve the work environment can be leveraged to be more inclusive of GME trainees. Ongoing work through the Clinical Learning Environment subcommittee at Parkland should be encouraged and expanded to the other training sites.
12. UT Southwestern UME leadership should be briefed on this report and engaged on potential areas for collaborative interventions to address the learner environment and trainee mistreatment. The shared clinical learning environment and interconnectedness of mistreatment concerns in UME and GME make collaborative interventions worth pursuing.
13. The Chief Wellness Officer and team should be briefed on this report and engaged on how ongoing institutional wellness initiatives can be more inclusive of GME trainees. Opportunities to include trainee-oriented sessions or tracks in upcoming Wellness symposia or events would be one example of potential collaboration.

Commentary:
The Task Force recognizes that any lasting interventions to improve residents' ability to raise concerns without fear or to change the overall learning climate cannot be restricted to GME and its programs. Collaborations with our partner hospitals as well as institutional partners at the UME and faculty level are essential. In this regard, we believe that the findings of this report may provide a launching point for discussions with these stakeholders with whom collaborative interventions are possible to improve the work and learning environment at UT Southwestern.

The Clinical Learning Environment subcommittee has already been engaged in this work at Parkland in conjunction with the CLER site visits, but this work should continue and be expanded to the other training sites. Collaborative opportunities with the UME leadership and Faculty Wellness offices should also be explored.

VII. Conclusion: Where do we go from here?

Despite the significant amount of time and effort that went into the work of this Task Force, we view this report as the beginning of a journey for UT Southwestern, both for GME and the institution as a whole. What began as a in-depth investigation of a specific concerning trend within our institutional ACGME survey results has provided a broader window and perspective on how we as an institution can create a safer and more effective learning climate for all those engaged in this educational mission—our faculty, our GME and UME trainees, and our support staff at each of our partnering healthcare institutions. Ultimately, as stated in the introduction, this goal of an improved learning climate matters to all of our various stakeholders because **the care team well-being is a prerequisite for achieving the other desired goals in healthcare**.[2] We believe that the insights gained and proposed recommendations contained in this report can provide a starting point and roadmap for how UT Southwestern's GME enterprise and its partners can move forward in this important task that is essential to its educational mission.

VIII. Acknowledgements

The Task Force members would like to acknowledge and express their gratitude to several individuals or groups, without whom this work would not have been possible.

First, we would like to thank the GME Leadership team at UT Southwestern—Dr. Larissa Velez (current Associate Dean of GME), Dr. Bradley Marple (previous Associate Dean of GME), and Dr. David Weigle (Assistant Dean of GME and Designated Institutional Official). Without their forward-looking vision, unwavering support, and commitment to this mission, this Task Force would never have come to fruition.

Next, we would like to thank the GME support staff for their technical support of the Task Force, particularly Megan Ping for her significant efforts as the Task Force administrative assistant and Deven Fuller for her assistance with the internal GME survey.

Next, we would like to thank Dr. Angela Mihalic, Dean of Medical Students and Associate Dean of Student Affairs, for her presentation on the ongoing UME efforts on the learner environment which provided valuable perspective to our own work.

Next, we would like to thank Dr. Suzanne Farmer, Assistant Vice President for Organizational Development and Training, and her two senior consultants, Kathy Murphy and Randy Hamrick, for their generous assistance in leading the Resident focus group interviews.

Next, we would like to thank all of various GME stakeholders who provided valuable feedback during this process and encouraged their trainees to participate in the surveys and focus group interviews, including the GMEC, the Chief Residents' Council, the Resident Wellness and Well-Being Subcommittee, and all of the UT Southwestern Program Directors and Program Coordinators.

Finally, we would like to express our immense gratitude to all of the residents and fellows at UT Southwestern, past and present, who contributed to our mission by completing either of the surveys or contributing to the focus group interviews. We especially want to thank the resident and fellow members of our Task Force. You chose to trust the Task Force with your experiences and your voice, and we dedicate this report and entire effort to you.

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X. Appendices

1. Internal GME Trainee Survey Questions

2. Summary Results from Internal GME Trainee Survey

3. Summary Themes from GME Trainee Focus Group Interviews

Appendix 1: GME Trainee Survey Questions (Version 6/2019)

Dear GME Trainees,

UT Southwestern is committed to promoting a clinical learning environment that nurtures altruism, accountability, duty, integrity and respect for others. Over the past several years, the topic of residents or fellows being able to raise concerns without fear has been identified as a target area for institutional improvement based on our ACGME survey results. To better understand the current learning climate and possible areas of concern, please complete the following survey that contains questions which closely resemble or expand on the ACGME Annual Resident Survey Questionnaire. Thank you for your time and participation.

1. In my program, I can raise problems or concerns without fear of intimidation or retaliation.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

2. Are you aware of the procedures for reporting or raising concerns within your training program?

- Yes
- No

3. I am satisfied with my program's process to deal confidentially with problems or concerns residents/fellows might have.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

4. Overall, my attending physicians have treated me with respect.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

5. Overall, my fellow trainees have treated me with respect.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

6. Overall, other clinical staff (e.g. nurses, pharmacists, techs, etc.) have treated me with respect.

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

7. During residency or fellowship training, how frequently if at all have you personally experienced or observed the following:

	Never	Rarely	Sometimes	Often	Very Often
A. Unprofessional behavior or mistreatment (e.g., physical threat, sexual harassment, offensive remarks based on gender/race/religion/sexual orientation)					
B. Discouraging from reporting patient safety concerns (e.g., errors or near misses in patient care)					
C. Unresolved interpersonal conflicts leading to a hostile work environment					
D. Inability to transition care or find backup when too fatigued to work					
E. Pressure to exceed or underreport duty hours					
F. Pressure to compromise integrity in clinical or research setting (e.g. misrepresent clinical documentation or research data, pressure to include non-participating attending as authors on manuscript)					

8. If you have personally experienced any of these behaviors, please indicate the source(s) of the behavior. Choose all that apply.

	Faculty	Resident/ Fellow	Student	Other Staff	Patient
A. Unprofessional behavior or mistreatment (e.g., physical threat, sexual harassment, offensive remarks based on gender/race/religion/sexual orientation)					
B. Discouraging from reporting patient safety concerns (e.g., errors or near misses in patient care)					
C. Unresolved interpersonal conflicts leading to a hostile work environment					
D. Inability to transition care or find backup when too fatigued to work					
E. Pressure to exceed or underreport duty hours					
F. Pressure to compromise integrity in clinical or research setting (e.g. misrepresent clinical documentation or research data, pressure to include non-participating attending as authors on manuscript)					

9.a) In general, how often did you report the above incident(s)?

- Always
- Sometimes
- Never

b) If yes, to whom did you report? (Free Text)

c) Were you satisfied with the response following your report of the incident? (Free Text)

10. If you did not report, please indicate the reason(s) that factored into your decision not to report.

Please choose all that apply.

- The incident did not seem important enough to report.
- I resolved the issue myself.
- I did not think anything would be done about it.
- Fear of reprisal or retaliation
- I did not know what to do or who to report it to.
- Other (please specify)

11.a) Has any of your education or clinical care been compromised by fear of retaliation?

- Yes
- No

b) If yes, from whom were you afraid of retaliation? (Choose all that apply)

- Attending faculty
- Other resident or fellow
- Medical Student
- Other Staff
- Other (please specify)

12. Are there any other comments related to the issue of raising concerns without fear that you would like to share? (Free Text)

Demographics (Optional)

Gender:

Ethnicity:

PGY Level:

In order to better understand and improve the clinical learning environment, it is very important for UT Southwestern to be aware of specific incidents when they occur. Because this survey is confidential and anonymous, we will not be able to address specific incidents through this survey. Please notify your program leadership or use your program's reporting procedures to address specific concerns that you may have. You can also access confidential and free resources through the Resident Wellness Center at phone number 214-648-9969 or https://www.utsouthwestern.edu/education/graduate-medical-education/wellness/wellness-center/

Thank you so much for taking the time to provide this important feedback.

Appendix 2: Summary Results from Internal GME Survey

The following represents the summary quantitative data from the internal GME survey conducted in June 2019 as part of the Task Force activities. Additionally, there were over 200 written comments submitted. Although these are not included due to space constraints and to preserve confidentiality, representative comments are presented in section V.D. of this report.

Demographics of Respondents:

- 293 total respondents (approximately 20% of total UT Southwestern GME trainees)
- Demographic information: 159 answered at least one of the optional questions
- Gender (out of 150): Female 58%
- Ethnicity (out of 116): AA/Black 6%, Asian 9%, Caucasian/White 66%, Latinx/Hispanic 13%, Other 4%
- PGY Level (out of 149): PGY1 16%, PGY2 18%, PGY3 10%, PGY4 25%, PGY5 and above 28%

General Questions about Fear of Reporting, Knowledge/Satisfaction with Reporting Mechanisms, and Respect in Learning Environment: (Questions 1-6)

Survey Question	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
1. In my program, I can raise problems or concerns without fear of intimidation or retaliation.	29%	38%	13%	14%	6%
3. I am satisfied with my program's process to deal confidentially with problems or concerns I might have.	24%	35%	18%	15%	8%
4. Overall, my attendings have treated me with respect.	40%	46%	9%	5%	0%
5. Overall, my fellow trainees have treated me with respect.	52%	36%	7%	3%	1%
6. Overall, other clinical staff have treated me with respect.	33%	45%	13%	5%	3%

Question 2: I am aware of the procedures for reporting or raising concerns within my training program. (Yes 78.5%; No 21.5%)

Questions about Type, Frequency and Source of Concerning Behaviors: (Questions 7-8)

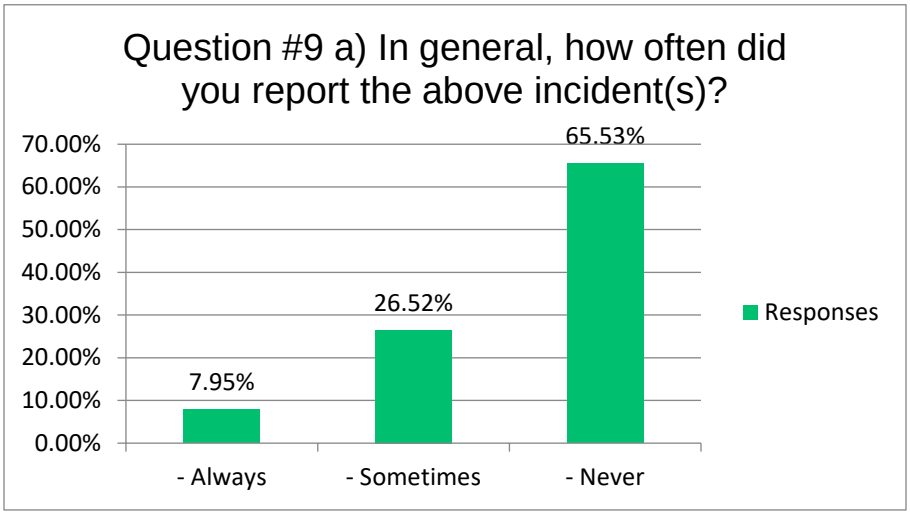
Question #7: During residency of fellowship training, how frequently if at all have you personally experienced or observed the following: (Answered on 5-point Likert scale with Never=1 and Very Often=5). Total respondents 292

Behavior (N = total respondents)	Never N (%)	Rarely N (%)	Sometimes N (%)	Often N (%)	Very Often N (%)	Weighted Average
A. Unprofessional behavior or mistreatment (e.g. physical threat, sexual harassment, offensive remarks) (N = 292)	130 (45%)	102 (34%)	46 (16%)	12 (4%)	2 (0.7%)	**1.82**
B. Discouraging from reporting patient safety concerns (e.g. errors or near misses in patient care) (N = 292)	213 (73%)	52 (18%)	22 (8%)	4 (1%)	1 (0.3%)	**1.38**
C. Unresolved interpersonal conflict leading to hostile work environment (N = 292)	105 (36%)	88 (30%)	66 (23%)	18 (6%)	15 (5%)	**2.14**
D. Inability to transition care or find backup when too fatigued to work (N = 290)	141 (49%)	61 (21%)	49 (17%)	20 (7%)	19 (7%)	**2.02**
E. Pressure to exceed or underreport duty hours (N = 292)	164 (56%)	57 (20%)	45 (15%)	14 (5%)	12 (4%)	**1.81**
F. Pressure to compromise integrity in clinical or research setting (e.g., misrepresent clinical or research data) (N = 291)	244 (84%)	31 (11%)	10 (3%)	5 (2%)	1 (0.3%)	**1.24**

Question #8: If you have personally experienced any of these behaviors, please indicate the source(s) of the behavior. Choose all that apply. (% can equal more than 100% if respondent experienced from multiple sources)

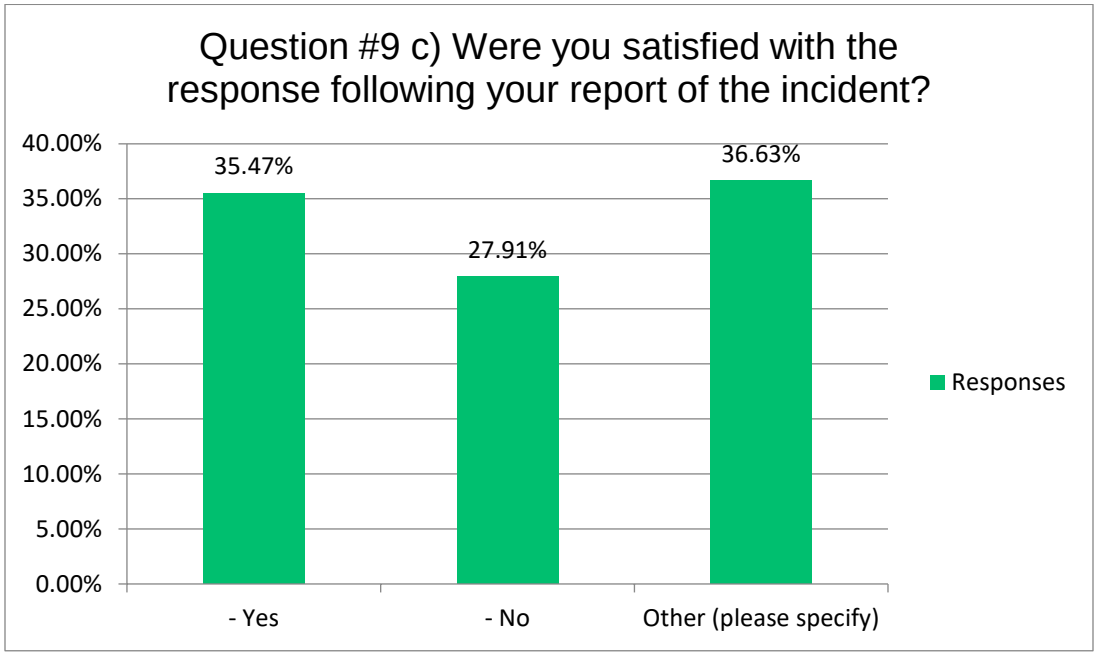
Behavior (N = total respondents)	Faculty N (%)	Resident/Fellow N (%)	Student N (%)	Other Staff N (%)	Patient N (%)
A. Unprofessional behavior or mistreatment (e.g. physical threat, sexual harassment, offensive remarks) (N= 147)	84 (57%)	40 (27%)	7 (5%)	44 (30%)	72 (49%)
B. Discouraging from reporting patient safety concerns (e.g. errors or near misses in patient care) (N = 53)	23 (43%)	20 (38%)	0 (0%)	21 (40%)	0 (0%)
C. Unresolved interpersonal conflict leading to hostile work environment (N = 151)	73 (48%)	69 (45%)	4 (3%)	62 (41%)	7 (5%)
D. Inability to transition care or find backup when too fatigued to work (N = 83)	48 (58%)	57 (69%)	0 (0%)	8 (10%)	0 (0%)
E. Pressure to exceed or underreport duty hours (N = 81)	49 (60%)	37 (46%)	0 (0%)	8 (10%)	2 (2%)
F. Pressure to compromise integrity in clinical or research setting (e.g., misrepresent clinical or research data) (N = 29)	25 (86%)	4 (14%)	0 (0%)	4 (14%)	0 (0%)

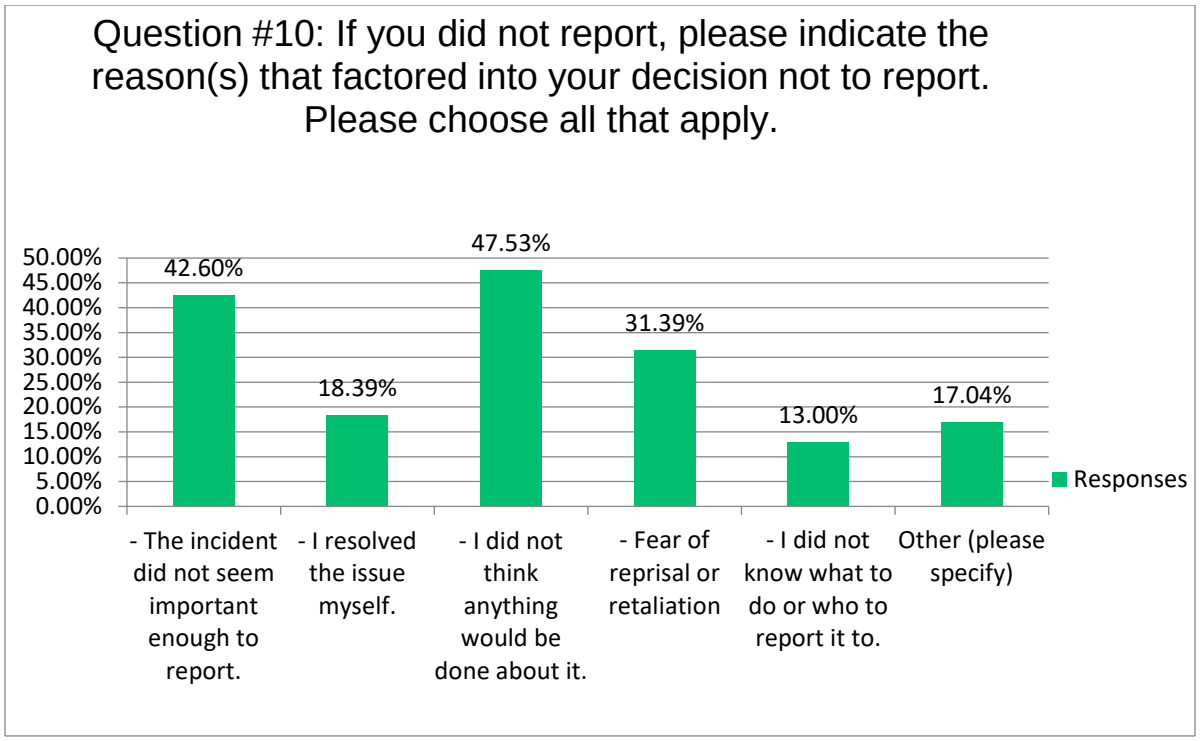
Questions about Reporting Frequency, Satisfaction and Reasons for Non-reporting: (Questions 9-10)



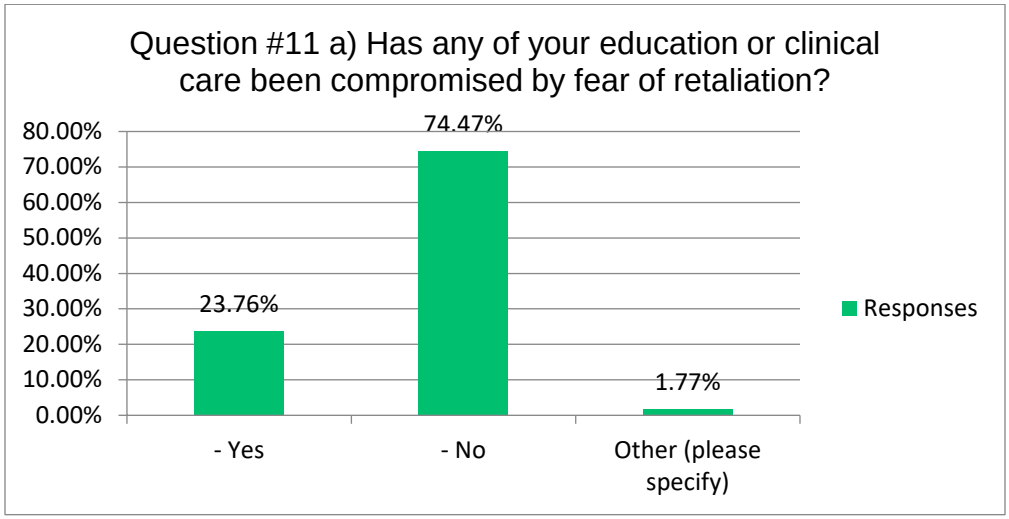
Question 9b: If the incident was reported, to whom did you report? (94 responses)

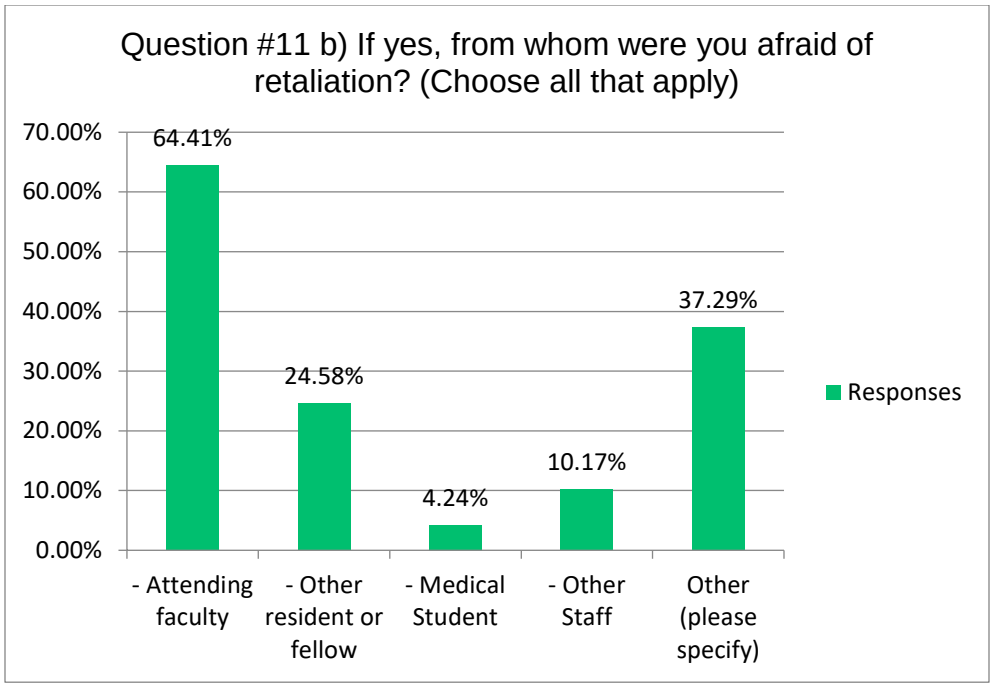
- Most common was to Program Director (about 50%)
- Next most common was either Chief Residents or other attendings
- Small number indicated other responses: Patient Safety Notice/Safety Link, Dept Chair, Hospital





Questions regarding Fear of Retaliation Compromising Education or Clinical Care (Question 11)




Question #11 b) If yes, from whom were you afraid of retaliation? (Choose all that apply)
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
64.41%
24.58%
4.24%
10.17%
37.29%
- Attending faculty
- Other resident or fellow
- Medical Student
- Other Staff
Other (please specify)
Responses

Appendix 3. Summary Themes from GME Trainee Focus Group Interviews

Six focus group Interviews were conducted with resident/fellow volunteers over the month of November 2019, led by senior consultants in the Department of Organizational Development and Learning, Kathy Murphy and Randy Hamrick.

Below are the questions that were asked to help guide the conversation and a de-identified summary of themes arising during the discussion:

1. Are you familiar with how or to whom to report issues?

- The majority of trainees answered that their reporting order would be Chief Residents followed by the Program Director.
- Some trainees answered that they would use a reporting order of Chief Residents, then Program Director, then Department Chair, then GME. The trainees that answered they would go to the Chair or to GME reported that they were more hesitant to report at this level.
- There was more confusion about whom to report to with issues concerning nurses/ attendings, hospitals, and transfers of services.
- Trainees knew about the online patient safety reporting, but they do not feel they have the time to report all issues.
- Most were not aware of the anonymous reporting in MedHub or reporting to employee relations.

2. Do you feel issues are resolved or resolved quickly?

- Trainees feel that Chief Residents and Program Directors address some issues quickly and communicate if and when something is resolved. If the problem needs to be handled by someone other than the Chief Residents or Program Director, more than likely, there is no communication.
- Some trainees reported that their program was hesitant to make major changes before a site visit.
- Many trainees reported that anything reported to Parkland Hospital will have no action that is communicated back to them.

3. What is working well in the current reporting processes?

- Addressing issues in the moment directly with those involved. Chief Residents and Program Directors address issues they can in a timely manner.
- One trainee stated that in a previous institution the GME program would send a quarterly update of issues that were brought up and how they were addressed or if they could be.
- One program has a therapist and advocate who obtains complaints collectively and brings those to leadership on behalf of trainees. This takes away some retaliation fears because complaints are presented as a collectively rather than individually.

- Some programs have regular meetings with Chief Residents to air out any complaints.
- One attending gets the phone numbers of trainees and texts updates and any feedback to them in the moment.
- One program has an outside faculty mentor who helps the trainee figure out how to address concerns.

4. What is not working in the current reporting processes?

- Rumor mill causes issues. If the problem is over the Program Director, there is little to no follow-up or follow through. When new ideas are presented, some trainees feel as though they are shut down because programs want to continue with what has historically been done.
- Hierarchy inhibits patient care at times.
- Epic communication for those who rotate to multiple hospitals- Nurses are not paging trainees, and this could potentially create patient safety issues.
- One trainee reported that they didn't receive direct abuse, but had emotional abuse. When this trainee brought up concerns, he/she was told he/she needed to change their outlook. Trainees are not treated with respect and no one sticks up for them.
- One trainee reported they have seen or experienced retaliation in the following forms: views being ignored, information withheld, impossible tasks given, public humiliation, gossip, and key responsibilities being removed.
- Another trainee reported retaliation in the form of psychological abuse, misconduct, and freedom taken away.
- ACGME Survey reviews conducted with faculty and trainees create intimidation where trainees do not want to report.
- When trainees ask for feedback, they sometimes get a 'deer in headlights' look from faculty.

5. What types of concern exist around reporting?

- Some trainees did mention a fear around retaliation, but most did not.
- Several trainees that mentioned a fear of retaliation said the fear to report is because they have been led to believe reporting can affect the accreditation status of the program they are in.
- Some MedHub evaluations have been shared with faculty, leading to a lack of trust in confidentiality.
- With regards to duty hour reporting, trainees have been encouraged to not report time charting outside scheduled time. The language of the MedHub 80 hour warning and the requirement for filling in the explanation is overwhelming.
- A few trainees reported that they did not feel as though they were getting training in some areas and were being treated as an assistant. When these trainees spoke directly to those treating them as an assistant, they received poor evaluations.
- One trainee expressed a concern to a hospital worker, who was offended by the concerns and reported the trainee in retaliation.

6. What is the training environment like?

- Some issues are due to leadership changes with new faculty who have a different vision for the program.
- Most trainees reported that there is an environment of open communication and that issues are addressed in a timely manner and directly with those involved.
- Some indicated the perception among faculty of an attitude that "I had it worse in my day". Some attending behavior feels like "hazing."

7. How important is your voice- do you feel heard?

- The majority of trainees feel heard, but it depends on the issue. Little issues are resolved quickly and feedback is given on these issues. Larger issues that go beyond the Program Director's control are not resolved, and no communication is given.

8. What improvements would you like to see?

- Trainees felt like they did not get an adequate UT Southwestern orientation for non-UTSW paid trainees.
- They would like to see programs be more open to ideas and to see a change in the culture of some programs.
- Some felt there is not a clear reporting system when it comes to hospital issues. They feel their Program Directors have little to no power to make changes.
- They requested more education about accreditation and how the ACGME Resident Survey can affect accreditation.
- Trainees requested a communication of findings from this focus group; if none is given, they will feel like their concerns went unrecognized.
- They encouraged training for those receiving complaints on how to address and receive them.