An Approach to Diagnosis and Treatment

Toxic Learning Environments

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Workshop Outline

• Plenary
• Barriers to “healthy” environments
• Case and approach
• Questions
Have you worked in a “TOXIC” environment?

- What issues have bought you here?
Connundrum - “Imbalance”

- Problem – relatively common
- Consequences – serious
  - Reputation
  - Accreditation
  - Retention
  - Recruitment

Advice – usually scarce

*resources may exist but unrecognised
“Definitions”

• What makes an environment unhealthy?
Features of “Toxic” Environments

CULTURE

• Lack of communication
• Lack of respect
• Lack of structure
• Lack of leadership
So what do you do?
Approach

• History
• Physical
• Diagnosis
• Treatment
Of course, you have to:

- Do it “right”
- You do not have to be an expert
- But you have to get help and combine expertise
Avoid early conclusions

• Don’t take a sketchy history
• Don’t make a hasty diagnosis
• Don’t expect a “quick fix”
Who’s a fan of 19th century poetry?

• John Godfrey Saxe (1816-1887)
The Blind Men and the Elephant

“It was six men of Indostan
To learning much inclined
Who went to see the elephant
Though all of them were blind
That each by observation
Might satisfy his mind”
History Taking

• Get the full story

• COMBINED Multi-source feedback necessary
  ➢ Learners (residents/students/fellows)
  ➢ Attendings, Divisional/Dept Chair, PD
  ➢ Administrative staff, PGME staff, other professionals
History Taking Continued

- Multiple history-takers
  - Dean, ADPGME, Assistant Dean (s),
  - Chief resident, Resident Association Rep.
  - RC Surveyors
Don’t email, Don’t phone!

• Interviews should be face to face
• “Safe” environment
Other than the interview

- Residents may feel safer composing a “group letter”
- Anonymous written examples also possible but carry less weight
- Aim for as much information as possible
Types of questions to ask:

- “Tell me about the environment here”
- Allow for general description, but then
  - Get SPECIFIC examples
Formulating Questions:

“Clinics are terrible” - not very helpful.

“Please Give me specific examples.”

- “Residents are always late.”
- “Supervisors don’t show up.”
- “There are not enough secretaries.”
- “Patient population is inappropriate.”
- “Computers often malfunction.”
Formulating Questions

• “What does not work well?”
Asking questions

Also ask: “What works well?” – look for the “silver lining”

May find unexpected “resources”
CHLORIDE PP

- Character
- Location
- Onset
- Radiation
- Intensity
- Duration
- Exacerbating
- Predisposing
- Palliating
Therefore:

- **Character:** What is going on?
- **Location:** What site(s)
- **Onset:** When did it start? Is it new or recurrent?
- **Radiation:** Who/what is affected?
- **Intensity:** How bad is it?
- **Duration:** How long has it been there?
- **Exacerbating factors:** Who/what is contributing?
- **Predisposing factors:** Is there something new that is making the environment more “susceptible” now?
  - How was it addressed in past?
  - What were the results? What were the consequences?***
- **Palliating factors:** Is anything/anyone helping? Is it known what could help? What are the wishes and expectations of those involved?
History Taking Continued

• Recurrent problems are more difficult to deal with
• Culture of “no one cares” often established

• Consequences crucial to resolution
The Physical

• Go to the source

• Meetings in ADPGME office less representative of situation

• Show willingness to go TO the problem

• Gain better understanding of the environment
The Physical continued

- Multiple meetings with stakeholders beneficial
- Ex.
- RTC
- Resident meeting
- Divisional Meeting
- Meet administrators/secretarial/allied staff members in their offices
- Get a tour of the facilities
“Imaging and test results”

• Review available documentation
  ➢ Accreditation history
  ➢ Survey reports
  ➢ Transmittal letters
  ➢ Rotation evaluations
  ➢ Evaluations of teachers
Imaging and test results continued

• Review documents at multiple levels

• University policies/procedures dealing with:
  • Promotions
  • Harrasssment/Intimidation
  • Safety Policies (PGME/ Program)
  • University Code of Conduct
  • Faculty Affairs
Imaging and test result continued

• Do not forget:
  • University organizational chart - ORGANOGRAM
  • Identify levels of responsibility
    ➢ Who reports to whom
    ➢ Who does/should do what
Diagnosis

• Once you have done a thorough Hx, PE and seen data

• **Make a diagnosis / diagnoses**

• If you CANNOT make a diagnosis, go back and look again
  ➢ Revisit steps
Diagnosis

• Make a problem list
  ➢ Usually there are several

• Be VERY specific
Approach

• Now what???
Approach

• Do not work alone
• Do not try to “solve” everything

• LISTEN

• Assemble a “working group”
• Multi pronged approach to problem with multiple prongs
  > NO PROBLEM IS AN ISOLATED THING OR PERSON
Approach

- Analyse diagnosis and problem list
- Like in medicine will have multiple issues
- Like medicine, may have multiple simultaneous “emergencies”
  - “Multi-organ system failure”
  - Require multiple consultants
Approach

• Present your problem list to *all* stakeholders
  - Vertical
  - Horizontal

• Prioritize most “urgent” and/or “largest” problems
Approach

• Identify what YOU will tackle and what you expect from others

• Again, be very specific
  ▶ Itemize
  ▶ Have time line
Be realistic

“You know, we’re just not reaching that guy.”
Approach

• “Early success” is important
  > Create an early goal that is important, and achievable
Approach

- List consequences of not succeeding
- (ensure support for consequences beforehand)
- Assume responsibility in consequences
- “OWN” the issue
Basics Matter

All I really need to know about how to live and what to do and how to be I learned in kindergarten. Wisdom was not at the top of the graduate-school matric for me, but there in the samples of Sunday School. These are the things I learned:

1. Share everything. If you have any friends in the world, they will smarten up when you share. At least they will if you have friends. If you don’t have friends, that’s a different story.

2. Wash your hands before you eat. This applies to adults as well. If you have any hands that are not yours, you should wash them before you eat.

3. Be sure your little heart is pure. Eat your vegetables. This applies to adults as well. If you have a little heart, you should eat your vegetables. If you don’t have a little heart, you should eat your vegetables anyway.

4. Clean your room. This applies to adults as well. If you have a room, you should clean it. If you don’t have a room, you should pretend you do.

5. Don’t hit boys. This applies to adults as well. If you have any boys, you should not hit them. If you don’t have any boys, you should hit them anyway.

6. The earth is a ball. This applies to adults as well. If you have a ball, you should think about the earth. If you don’t have a ball, you should think about the earth anyway.

7. When you go out into the world, watch out for traffic, old men,lices, and ducks.

8. Be aware of weather. Remember the little word in the weather map. The rest goes up and down and nobody really knows how or why, but we are all like that. We didn’t make the rules and we don’t know them and we are just like that.

And then remember the Dick-and-Jane books and the first word you learned—the biggest word of all—LOOK. Everything you need to know is in three volumes. The Golden Book and live and these two, nature, ecology and politics and equality and some strange. Take any one of these “weird” and extract it into sophisticated adult terms and apply it to your family life or your work or your government or your world and it holds true and dear and firm. This is what a better world would be if we all—that wide, world—had cookies and milk about three o’clock every afternoon and then lay down with our blankets for a nap. Or if all governments had a basic policy to always patch things back where they found them and to clean up their own messes.

And it is true that, as smart as you are—if you go out into the world, it is best to laugh and wince together.}

By Robert Fulghum
Approach

• Follow up regularly

• Chronic problems have chronic solutions
Toxic Environment

Case Study
Case Presentation

• Mid-size residency Program
• “Intent to withdraw” on last Accreditation visit
  ➢ (1.5 years prior)
• Internal “Practice” review approaching
  ➢ ~5 months
• and Royal College Mandated External Review
  ➢ ~11 months
Team Assembled

- Associate Dean, PGME
- Assistant Dean, Resident Professional Affairs
- Director of Accreditation
History taking

- Multiple stake-holders interviewed
- PD
- Residents
- RTC
- Faculty
- Division Chair
- Administrator
“What works well?”

• “NOTHING”
What is not working?

• Question asked at multiple face-to-face meetings
• Specific examples generated a lot of information
History

PD

Multiple face to face meetings

- Designation “unfair”
- “Good Program” – or “not that bad”
- Surveyor “too picky”
- PGME Office “unhelpful”
  - PGME Office did not help with issues brought forth by PD in past
PD

- Administrator worked well with PD
- Residents motivated
- Several Faculty members pushing for change
History

Residents

• Group Letter written, multiple face-to-face meetings held
• Perceptions:
  • PD helpful but “most other” Attendings not
  • Poor role modeling with Attendings “trashing” each other at educational activities
  • Either no feedback or not effective
  • Lack of teaching
  • Junior residents harassed by seniors who emulated Staff MD (though “getting better” since Program put on “Intent”)

50
Residents

• PD and administrator well-liked
• Residents becoming a “team”
RTC Committee

• Face to face meetings

• Initial meeting: _No_ buy-in
• “It’s not me”
• “It’s not at our site”
• Residents “not what they used to be”
• Royal College “too sensitive”
• We “don’t have time” (for mumbo jumbo)
• “Nothing ever changes”
• “No one helped last time”
RTC

- Desire for change present
Meeting with Faculty – “Scapegoating”

• One attending in particular targeted by other members of Faculty
  ➢ Though multiple attendings identified
  ➢ “HE caused it”.
  ➢ “It’s all HIS fault.”
• Attending in question on remediation
• High position within hospital, excellent clinician and administrator
  ➢ Lawyers involved
Faculty

- Recognized implication on practice, patients
- Consequences grave
Division Chief

- Leadership in transition
- “Chronic” problem
- Perception of PGME Office as chronically unsupportive
Chief

- Did not want legacy to include Program closure
Administrator

• Looking for another position
• Discouraged
• Exhausted
Administrator

- Devoted to Program
- “Expert” in field
CHLORIDE

- **Character:** Intimidation/poor role modelling/ no teaching/ no feedback
- **Location:** What site(s): ALL
- **Onset:** When did it start? Is it new or recurrent? - RECURRENT
- **Radiation:** Who/what is affected? RESIDENTS/FACULTY/ SUPPORT STAFF/ PGME/ DEAN
- **Intensity:** How bad is it?: BAD
- **Duration:** How long has it been there? : YEARS
- **Exacerbating factors:** Who/what is contributing? SEE- RADIATION
- **Predisposing factors:** Is there something new that is making the environment more “susceptible” now?
   - RECURRENT ISSUE PERCEIVED AS POORLY HANDLED, STRESS OVER REVIEW AND STANDING, MOVE TO NEW SITE
- **Palliating factors:** Is anything/anyone helping? PGME, DEAN, PD, RESIDENTS, SOME FACULTY, ADMINISTRATOR
- Is it known what could help? : CONSEQUENCES and RESOURCES
- What are the wishes and expectations of those involved? COMMITMENT FROM ALL TOWARD CULTURE CHANGE
Physical

• Meetings held at Program sites

• Service transitioning to larger center but no major physical space issues
Results of “Imaging”

• Accreditation reports specified harassment, lack of teaching, lack of feedback
• Rotation evaluations and teacher evaluations corroborated
Problem List

- Unprofessional behaviour exhibited by Attendings - belittling trainees, each other
- Lack of teaching at all sites
- Lack of formal feedback, poor feedback quality (including belittling, intimidation)
- Poor administrative morale
- Residents and Attendings “lost faith” in Program and PGME, Dean and University
Approach

- Residents, Attendings, PD, Chief, Administrator, Dean Of Medicine all informed
- Priorities identified:
  - Intimidating culture
  - Poor teaching
  - Lack of feedback/poor quality
  - Lack of unity
  - Lack of ownership by PGME/university
Approach

• Working Group Assembled by ADPGME

• ADPGME made himself and working group accountable for being **physically present** and guiding progress throughout entire process
Approach

• **Many** additional meetings held
  
  • **ADPGME:** Dean, Chief, PD, Faculty, RTC, Admin, Residents
  
  • **Assistant Dean Resident Affairs:** Faculty, RTC, Admin, Residents
  
  • **Director of Accreditation:** PD, Faculty, RTC, Admin, Residents
Educational Sessions Created and Provided

- To Residents and Attendings
- McGill Complaint Process
- How to initiate a complaint
- What constituted grounds for complaint
- How various complaints are handled by university
  - Ex. Harassment by residents vs by Faculty
  - Reach of PGME vs Faculty Affairs
Educational Sessions

• CME workshop – understanding CanMEDS
  ➢ (Associate Dean for Faculty Development) RTC/Faculty

• Accreditation Process session
  ➢ Overview of Accreditation Process
  ➢ Program’s weaknesses and strengths
  ➢ Meaning of current standing
  ➢ Implications

• Accreditation workshop – PD and admin only (McGill wide)
Educational Sessions

• Were mandatory
• Obligatory participation monitored by PD and Division Chair
• Feedback on participation and “behaviour” also reported to ADPGME and Dean of Medicine
Practice Survey also organized

- Internal Surveyors specifically selected for expertise
After practice review and education sessions

• Faculty buy-in still suboptimal

• But

  ▶ Confidence gained in PGME/university regarding presence, support, advocacy
Stepping up the ante

• Culture change slowly evolving

• But not enough
High-Level Intervention

• Mandatory Simulation workshop
• For all Faculty (including Chief)
• Actors hired to SHOW Faculty how they were seen
• Realistic scenarios created with collaboration with PD and a number of involved Program Faculty
  ➢ Realistic language, setting, “costumes”
Approach

• Professional actors were trained in hi-fi demonstration
• 3 scenarios to showcase the 3 biggest problems presented to attendings, with specific examples
  > Belittling/harassing residents
  > Poor feedback
  > “Trashing” each other
Results of Simulation “Intervention”
Eureka!

• “That’s ME!”
• “I know EXACTLY who said that!”
• “That sounds just like so and so!!!!!!”
Debriefing with Entire Faculty

- Very successful
- Moderated by “Working Group”
- Signaled seismic “shift” in attitude
Approach – Communicating about “Therapy”

• Bilateral

• Intervention and aims also transmitted to residents
  ➢ Asked to monitor results and provide honest feedback to PD, PGME

• Dean of Medicine also updated
  ➢ planned follow up with Division Chief, PGME
Adherence to “Therapy”

• Follow-up meetings held
  ➢ Reiterate understanding gained through simulation

• CanMEDS reviewed again

• Faculty feedback sought

• Resident, Administrator and Dean observations (positive) communicated again to ALL
Timeline

RC Survey Day

<1 mo prior: meet Faculty, RTC, PD, admin, residents, Chief

2 mo prior: Simulation Workshop

5 months prior: Practice Survey

11 months prior: meetings by “Team” with ALL stakeholders, CanMEDS workshop, Accreditation education session, Accreditation workshop
First Impression of Final Results

- **Transformation** in progress!
- Morale *much* better
- Attendings giving *each other* feedback on what they did well and what could be done better!
- CanMEDS grasped by *all*
- Understanding of university processes much improved
- Own code of conduct *initiated and completed* by program
Official Results

- Royal College External Review:
- “Accredited Program with Next Regular Survey”
- All existing weaknesses addressed
- No new weaknesses
Summary

- Not an isolated case
- Approach used 6 times so far
- Problems are always different, but approach can be the same
  - Work with like-minded others
  - Get many perspectives
  - Get specific examples of what doesn’t work and what does
  - Address these specific problems
  - Be present
  - Be accountable
  - Listen
Thank-you!

• Questions?
Help us improve.  
Your input matters.

• Download the ICRE App,

• Visit the evaluation area in the Main Lobby, near Registration, or

• Go to:  
  http://www.royalcollege.ca/icre-evaluations to complete the session evaluation.

Aidez-nous à nous améliorer.  
Votre opinion compte!

• Téléchargez l’application de la CIFR

• Visitez la zone d’évaluation dans le hall principal, près du comptoir d’inscription, ou

• Visitez le  
  http://www.collegeroyal.ca/evaluations-cifr afin de remplir une évaluation de la séance.

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