Whereas, Bullying and disrespectful behavior within the practice of medicine in the U.S. and overseas has been well demonstrated in prior studies, and that perpetrators of bullying within medicine can be other physician colleagues, superior ranking colleagues in training, ancillary staff, and patients; and

Whereas, “Bullying or aggressive behavior has been defined by criteria such as: intention to cause harm or distress, imbalance of power between the bully (perpetrator, aggressor) and the victim (target), and repeatability over time,” and the British Medical Association defines bullying as “persistent behaviour against an individual that is intimidating, degrading, offensive or malicious and undermines the confidence and self-esteem of the recipient; and

Whereas, Disrespectful behavior “encompasses a broad array of conduct, from aggressive outbursts to subtle patterns of disruptive behavior so embedded in our culture that they seem normal,” and disrespectful behavior can also be considered “any behavior that influences the willingness of staff or patients to speak up or interact with an individual because he or she expects the encounter will be unpleasant or uncomfortable; and

Whereas, A survey published in 2008 found in the United States “A total of 77% of the respondents reported that they had witnessed disruptive behavior in physicians at their hospitals; and

Whereas, A 2013 survey from Institute for Safe Medication Practices exposed “healthcare’s continued tolerance of and indifference to disrespectful behavior. Despite more than a decade of emphasis on safety, little improvement has been made; and

Whereas, One U.S. Longitudinal survey of medical students published in 2006 demonstrated that “most medical students in the U.S. reported having been harassed or belittled during their training; and

Whereas, Fnaïs et al in a 2014 meta-analysis found that “59.4% of medical trainees had experienced at least one form of harassment or discrimination during their training, with verbal harassment being the most commonly cited form of harassment; and

Whereas, “Workplace bullying is associated with stress, depression, and intention to leave” and increased “absenteeism, career damage, poorer job performance, and lower productivity resulting in poorer quality of healthcare services and patient care; and

Whereas, “Victims of bullying suffer from anxiety, loss of self-control, depression, lower self-confidence, occupational job stress, job dissatisfaction, dissatisfaction with life, burnout
syndrome, musculoskeletal complaints, increased risk of cardiovascular disease, suicide attempts, and drug abuse” and disrespectful behaviors “have been linked to adverse events, medical errors, compromises in patient safety, and even patient mortality”

Whereas, The Joint Commission in 2008 issued an alert “warning that offensive and hostile behavior among healthcare professionals not only makes for an unpleasant working environment but can also pose a considerable threat to patient safety”

Whereas, Creswell et al describe how British medical schools are integrating curricula to teach students how to differentiate undermining and destructive bullying behavior from constructive and supportive firm supervision, and how take action against bullying and positive teaching methods have been recommended within medical education, and formal procedures to safely, accurately, and freely report bullying are needed in order to protect bullying victims and address the issue; therefore be it

RESOLVED, That our American Medical Association help establish a clear definition of professional bullying, establish prevalence and impact of professional bullying, and establish guidelines for prevention of professional bullying with a report back at the 2020 Annual Meeting.

(Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/04/19

References:
RELEVANT AMA POLICY

Teacher-Learner Relationship In Medical Education H-295.955

The AMA recommends that each medical education institution have a widely disseminated policy that: (1) sets forth the expected standards of behavior of the teacher and the learner; (2) delineates procedures for dealing with breaches of that standard, including: (a) avenues for complaints, (b) procedures for investigation, (c) protection and confidentiality, (d) sanctions; and (3) outlines a mechanism for prevention and education. The AMA urges all medical education programs to regard the following Code of Behavior as a guide in developing standards of behavior for both teachers and learners in their own institutions, with appropriate provisions for grievance procedures, investigative methods, and maintenance of confidentiality.

CODE OF BEHAVIOR

The teacher-learner relationship should be based on mutual trust, respect, and responsibility. This relationship should be carried out in a professional manner, in a learning environment that places strong focus on education, high quality patient care, and ethical conduct.

A number of factors place demand on medical school faculty to devote a greater proportion of their time to revenue-generating activity. Greater severity of illness among inpatients also places heavy demands on residents and fellows. In the face of sometimes conflicting demands on their time, educators must work to preserve the priority of education and place appropriate emphasis on the critical role of teacher. In the teacher-learner relationship, each party has certain legitimate expectations of the other. For example, the learner can expect that the teacher will provide instruction, guidance, inspiration, and leadership in learning. The teacher expects the learner to make an appropriate professional investment of energy and intellect to acquire the knowledge and skills necessary to become an effective physician. Both parties can expect the other to prepare appropriately for the educational interaction and to discharge their responsibilities in the educational relationship with unfailing honesty.

Certain behaviors are inherently destructive to the teacher-learner relationship. Behaviors such as violence, sexual harassment, inappropriate discrimination based on personal characteristics must never be tolerated. Other behavior can also be inappropriate if the effect interferes with professional development. Behavior patterns such as making habitual demeaning or derogatory remarks, belittling comments or destructive criticism fall into this category. On the behavioral level, abuse may be operationally defined as behavior by medical school faculty, residents, or students which is consensually disapproved by society and by the academic community as either exploitive or punishing. Examples of inappropriate behavior are: physical punishment or physical threats; sexual harassment; discrimination based on race, religion, ethnicity, sex, age; sexual orientation, gender identity, and physical disabilities; repeated episodes of psychological punishment of a student by a particular superior (e.g., public humiliation, threats and intimidation, removal of privileges); grading used to punish a student rather than to evaluate objective performance; assigning tasks for punishment rather than educational purposes; requiring the performance of personal services; taking credit for another individual's work; intentional neglect or intentional lack of communication.

On the institutional level, abuse may be defined as policies, regulations, or procedures that are socially disapproved as a violation of individuals' rights. Examples of institutional abuse are: policies, regulations, or procedures that are discriminatory based on race, religion, ethnicity, sex, age, sexual orientation, gender identity, and physical disabilities; and requiring individuals to perform unpleasant tasks that are entirely irrelevant to their education as physicians.

While criticism is part of the learning process, in order to be effective and constructive, it should be handled in a way to promote learning. Negative feedback is generally more useful when delivered in a private setting that fosters discussion and behavior modification. Feedback should focus on behavior rather than personal characteristics and should avoid pejorative labeling.

Because people's opinions will differ on whether specific behavior is acceptable, teaching programs should encourage discussion and exchange among teacher and learner to promote effective educational strategies. People in the teaching role (including faculty, residents, and students) need guidance to carry out their educational responsibilities effectively.

Medical schools are urged to develop innovative ways of preparing students for their roles as educators of other students as well as patients.

Violence and Abuse Prevention in the Health Care Workplace H-515.966
Our AMA encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees.
Citation: Res. 424, I-98; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13; Modified: CSAPH Rep. 07, A-16

Reduction of Online Bullying H-515.959
Our AMA urges social networking platforms to adopt Terms of Service that define and prohibit electronic aggression, which may include any type of harassment or bullying, including but not limited to that occurring through e-mail, chat room, instant messaging, website (including blogs) or text messaging.
Citation: Res. 401, A-12