Issues Related to Intimidation, Bullying, Harassment and Sexual Harassment in the Faculty of Medicine, Memorial University: Unit Assessment Report

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Summary

In November 2017, Dr. Margaret Steele, Dean of the Faculty of Medicine met with Dr. Gary Kachanoski, President and Vice-Chancellor of Memorial University of Newfoundland to initiate an assessment of the Faculty of Medicine relating to issues of intimidation, bullying, harassment and sexual harassment (IBH&SH) and to a safe and respectful learning environment. Specifically I was asked to make recommendations about internal policies and procedures within the Faculty of Medicine and their alignment with the applicable policies at Memorial. As well I was asked to assess the culture and learning environment as it relates to reporting and response to incidents of IBH&SH.

To accomplish this task I met with 32 official stakeholders who held administrative or key positions in the Faculty of Medicine or elsewhere at Memorial University, or were experts in the field of harassment and sexual harassment. I also spoke with representatives from medical schools at Dalhousie University, Western University, and the University of British Columbia to assess the policies, processes and administrative structures in place to respond to issues of IBH&SH. As well, 36 students, faculty members, and staff members responded to an invitation to meet with me confidentially or send in a confidential written submission about the issue. I also conducted a review of the medical literature related to IBH&SH.

My overall impression of the culture of Memorial’s Faculty of Medicine is that it is generally a respectful environment and a good place to learn and work. However, there is a culture of tolerance of disrespectful and harassing behaviour by some individuals in some areas. As well, there is concern about some gender-related issues.

This report contains 39 recommendations on areas related to: enhancing trust and confidence, policy, education, administrative structures, reporting, communication, and culture. Recommendations are made for additional resources to support the Sexual Harassment Office and for new resources to deal appropriately with equity issues in the Faculty of Medicine and at Memorial University.
Chapter One: Introduction and Process of the Unit Assessment

Memorial University of Newfoundland is a highly respected academic institution that has as its vision to be one of the most distinguished public universities in Canada and beyond. A number of Memorial’s core values centre on integrity, (being honest and ethical), collegiality (engaging others with respect, openness and trust), as well as inclusivity and diversity. The Memorial University of Newfoundland Code states: “All members of the Memorial University Community, which includes students, faculty, and staff, shall treat others with respect and fairness, be responsible and honest, and uphold the highest standards of academic integrity.” Clearly, Memorial University sets a high standard of behaviour and achievement in order to meet its obligation to society and the public good.

Likewise, Memorial’s Faculty of Medicine is committed to acting with integrity and professionalism and providing learners, faculty and staff with a supportive environment so that everyone can reach their full potential. The teaching, research, clinical service and other activities conducted by those in the Faculty of Medicine are critically important to meeting the current and future health needs of the people of this province and elsewhere. That is why we all need the Faculty of Medicine to be the best it can be in order to fulfill its stated mission:

“Working in a spirit of partnership and respect, the Faculty of Medicine is committed to delivering integrated excellence in education, research and evidence informed care; meeting the unique health needs of our rural, remote and urban communities; and advocating for health, equity, indigenous health and healthy populations”. (Faculty of Medicine, Strategic Plan, Destination Excellence 2018-2023).

One of the hallmarks of educational institutions is an openness to critically review its operations and processes in order to acknowledge problems and make improvements. While this can be difficult, it is a necessary step towards positive change. This unit assessment will hopefully be a step in that direction.

As a caveat to this report, I need to acknowledge up front that I believe the vast majority of learners, educators, clinicians, researchers, administrators and staff who study, teach and work in Memorial’s Faculty of Medicine and those who work in regional health authorities in this province adhere to high ethical standards and display respectful, professional behaviour in their interactions with others.
I also wish to acknowledge my thanks to everyone who came forward to speak with me or send me their thoughts about the learning and working environment in the Faculty of Medicine and Memorial University. I recognize that it took courage to do so. Everyone I spoke with came with the intent to make things better for the future. I also wish to thank Dr. Margaret Steele, her office team and many others for the help they provided to me. Thanks also to Dr. Gary Kachanoski for the opportunity to conduct this unit assessment.

**Process**

In November 2017, Dr. Margaret Steele, Dean of the Faculty of Medicine (FOM) met with Dr. Gary Kachanoski, President and Vice-Chancellor of Memorial University of Newfoundland to initiate an assessment of the FOM relating to issues of intimidation, bullying, harassment and sexual harassment (IBH&SH). *(See Appendix A.)* I was appointed as the unit assessor in early 2018 and began my work on January 15.

My task was to gather information that relates to IBH&SH and to a safe and respectful learning environment in the FOM. Specifically I was asked to make recommendations about internal policies and procedures within the FOM and their alignment with the applicable policies at Memorial, namely the *Sexual Harassment* and *Sexual Assault Policy/Procedures* and *Respectful Workplace Policy/Procedures*. As well I was asked to assess the culture and learning environment as it relates to reporting and response to incidents of IBH&SH. *(See Terms of Reference - Unit Assessment Faculty of Medicine, Appendix B).*

To accomplish this task, I met with 32 official stakeholders and researchers either in private in-person meetings, by phone, or by email. These individuals were contacted by me initially or contacted me because of their official roles in the FOM. They include: FOM administrators and staff who provide support to learners, faculty and staff on issues of IBH&SH; program directors, discipline chairs, and clinical chiefs; individuals involved in policy development and implementation in the FOM and at Memorial; Memorial’s sexual harassment advisor; and, a legal education and human rights consultant. I contacted a medical education researcher from Queen’s University and a researcher in the Faculty of Business at Memorial, both of whom work in the area of IBH&SH. In addition, I spoke with representatives from three Canadian Medical Schools: Dalhousie University, Western University, and the University of British Columbia to assess the policies, processes and structures in place to respond to issues of IBH&SH at their institutions. *(See Appendix C for names of the offices contacted).*
I also issued email invitations to all learners, faculty and staff in the FOM to provide me with feedback on any issues related to the culture and learning environment regarding IBH&SH. Feedback could be either in writing or delivered in a private confidential meeting with me. Both my email invitation and Dr. Steele’s memo about the unit assessment made clear that I was not investigating individual complaints but would respectfully listen to their concerns, report on the issues presented, and use this information to inform recommendations made.

I met with or corresponded with 36 individuals: 10 undergraduate learners, five graduate students, six postgraduate learners, five clinical faculty, two academic faculty, and eight staff members. When I met with individuals who came forward to discuss an experience of IBH&SH, I asked five questions: 1) what happened; 2) what action was taken or not taken; 3) what were the barriers or facilitators to invoking established policy; 4) what would have helped; and 5) what is your assessment of the culture in the FOM regarding intimidation and harassment. With permission, I took notes at each meeting and then summarized each discussion under those five headings.

In total, I communicated with 66 individuals: 50 in-person interviews, seven phone interviews, and nine written submissions. In six instances, I met with individuals a second time or received a written submission after the in-person interview. I also met regularly with Dr. Margaret Steele, Dean FOM to keep her abreast of my progress. I also reviewed a large number of FOM and Memorial policies and documents and other documents. (See Appendix D).
Chapter Two: Literature Review

Intimidation, Bullying, Harassment and Sexual Harassment in Medicine

To better understand the issue of intimidation, bullying, harassment and sexual harassment in medicine, I conducted a selective review of the recent literature in the field. This was by no means exhaustive, but was meant to give me an indication of the recent research findings, some best practices, and opinions on this complex phenomenon. I also paid attention to reports in the media about sexual harassment that were circulating while I was conducting this assessment. While it may be unusual to include a literature review in a report of this kind, I feel it is important to set the stage for the information presented in the following chapters. It clarifies that the issues raised in this unit assessment are not unique to Memorial’s Faculty of Medicine.

How common is bullying, intimidation, harassment and sexual harassment in medicine?

The issue of intimidation, bullying, harassment and sexual harassment (IBH&SH) in medicine is not new. In 1982 a paper by Silver brought attention to the issue of medical student mistreatment. He observed that some students changed from “alert” and “enthusiastic” in their early years in medical school to “cynical, dejected, frightened or depressed” by the time they finished training. Might student mistreatment be part of the reason for the change? Subsequent studies provide support for the scale of mistreatment of medical students. In 2014, a team from St. Michael’s Hospital in Toronto conducted the first systematic review and meta-analysis of 59 studies published from 1987 to 2011 on harassment and discrimination in medical training programs. Thirty seven studies were conducted in the United States or Canada, with the rest mostly from the United Kingdom, Pakistan, Israel and Japan. Undergraduate medical students including clinical clerks were included in 32 studies, postgraduate residents in 24, both in one study, and interns in three studies. Results extracted from these studies represent 33,736 medical trainees.

The authors found that 60% of undergraduate medical students including clinical clerks and 63% of postgraduate residents had experienced some form of abuse (e.g., verbal, sexual, physical abuse, academic harassment, gender discrimination or racial discrimination) while in their training programs. The most common sources of harassment and discrimination overall were: consultants and senior physicians, patients and patients’ families, fellows/residents, nurses and others including faculty and other students. Trainees in 32 studies reported an average of four sources of abuse (range 1-8). The most common type of abuse was verbal harassment for undergraduate students while residents cited gender discrimination followed by verbal harassment as the most
common. As well, sexual harassment was reported by 33% of undergraduates and 36% of residents, and was more likely to occur to female trainees.

Recent reports of residency training programs in Australia in 2015 and 2016 identified “widespread” discrimination, bullying and sexual harassment in the practice of surgery\textsuperscript{3,4} and in other specialties such as intensive care medicine\textsuperscript{5}. These findings have prompted the development of a comprehensive action plan titled: “\textit{Building Respect, Improving Patient Safety}” that outlines goals and actions to be taken in three areas: culture change and leadership, education, and complaints management\textsuperscript{4}.

Recent articles published in the Canadian Medical Association Journal have brought this issue closer to home\textsuperscript{6,7}. Vogel reported the official associations for medical residents in Quebec and English Canada first called attention to widespread harassment and intimidation of medical trainees in 1996\textsuperscript{6}. By 2011 and 2012, the situation had not improved with 45% of family medicine residents in Alberta reporting intimidation, harassment and discrimination during their training\textsuperscript{8} and 72% of 2305 medical residents in 13 Canadian university programs from all specialties reporting inappropriate behaviour by others that made them feel diminished\textsuperscript{9}. This was often in the form of persistent attempts to belittle or humiliate the trainee in front of colleagues.

At the most recent Canadian Medical Association Annual Meeting held in 2017, the president of the Canadian Federation of Medical Students recounted his own experience with bullying and intimidation in Ontario\textsuperscript{7}. He stated that “these experiences really shook me in how I perceived the medical profession and how we treat one another”. He described the tolerance for abuse as “part of the culture of our profession” but that the culture has to change with zero tolerance for abuse in medical schools and health care settings. He added that medical trainees and other marginalized groups are particularly vulnerable to abuse because of the power differential between senior physicians and trainees.

In contrast to the studies of medical trainees, there are few research reports of various forms of mistreatment of fully qualified physicians in academic medicine and health care workplaces. A 2016 survey\textsuperscript{10} of 664 UK obstetrics and gynaecology (OB/GYN) specialists states that it is the first investigation into bullying and undermining of senior specialist physicians as victims of abuse rather than as perpetrators. Forty-four percent of specialists reported they were persistently bullied or undermined, mostly by other physicians who were senior or close to them in hierarchy. These numbers suggest that 14% of OB/GYN consultants in the UK are targets of workplace abuse. The types of behaviours reported were persistent attempts to belittle and undermine an individual’s work or integrity, persistent or unjustified criticism and monitoring of work, and freezing
out, ignoring or excluding the individual’s efforts. Few physicians in this study reported sexual or physical abuse. Both males and females were targets of bullying and both males and females were sources of the abusive behaviour.

Since at least 1972\textsuperscript{11}, reports of sexual harassment, gender bias and discrimination experienced by mostly women physicians and medical students have been published in the medical literature. Here are just a few examples:

- A 1998 report on the US Women Physicians Health Study found that 48\% of women physicians reported gender-based or sexual harassment occurring most often during medical training. However, a quarter of harassment experiences occurred after they were fully qualified\textsuperscript{12}.
- Another American study published in 2000 reported that 52\% of 953 female faculty in academic medicine had experienced sexual harassment compared to 5\% of 1,010 male faculty\textsuperscript{13}.
- A 2014 survey of 1066 medical faculty who held a National Institutes of Health career grant found that 30\% percent of the female clinician-researchers had experienced sexual harassment and discrimination compared to 4\% of men\textsuperscript{14}.

In the wake of the \#MeToo movement (2017-18) that began with reports of sexual harassment in the movie industry, many recent publications are calling for zero tolerance for sexual and gender harassment in academic medicine and science\textsuperscript{15-19}. Authors of these articles represent women physicians and academics from across the United States - from Harvard to University of California San Francisco. The article by Shakil and colleagues titled: Persistence of Sexual Harassment and Gender Bias in Medicine Across Generations – Us Too\textsuperscript{16} stated:

“Our goal in publishing this perspective is to highlight a shared and distressing female experience: to be a woman in medicine, whether in training or in a senior role, includes the unique challenge of facing sexist behavior from patients and even colleagues on a regular basis in an already stressful work environment. The impact of a cascade of small injustices that women physicians deal with everyday undermines our daily work and collectively sends a demeaning message about our worth in the work place”.

What is the impact of mistreatment on trainees and practicing physicians?

Medical school and residency training are by their very nature challenging and stressful. Some stress is expected as part of the learning that occurs in the classroom and in multiple complex clinical settings. While some stress is positive and can stimulate
learning, behaviours that humiliate, disrespect or intimidate trainees are largely detrimental to learning and mental health\textsuperscript{1,8,9,20}. Bullying, intimidation and harassment in all its forms during medical training can have far-reaching negative effects on an individual’s mental and physical health, personal relationships, and career satisfaction.

Studies report that medical students in clinical clerkship (years 3 and 4) are resilient in the face of multiple traumatic stressors in the clinical environment such as exposure to patient suffering and death\textsuperscript{21}, but exhibit increased rates of anxiety, depression and post-traumatic stress when exposed to recurrent personal mistreatment or witnessing of unprofessional behaviour or poor role modeling by supervisors\textsuperscript{21,22}. Witnessing disrespectful behaviour may be as damaging as receiving it because it reduces psychological safety in the learning environment\textsuperscript{22,23}. Other impacts include binge drinking, suicidal thoughts, low career satisfaction, loss of confidence, and a higher risk for burnout or emotional exhaustion early in their career\textsuperscript{22,24,25}. Female medical students exposed to repeated ‘gendered’ unprofessional comments and behaviours during their third year report feeling guilty and describe undergoing a process of desensitization and resignation to the fact such events would occur during their professional training\textsuperscript{27}.

Mistreatment of postgraduate residents or witnessing such behaviour can cause psychological distress, anxiety, depression, insomnia, appetite loss, poor morale and motivation, and impact on patient safety and quality care\textsuperscript{2,8,9,20,23}. Resident stress and depression has been linked to burnout, depersonalization and cynicism, feelings of inadequacy, dissatisfaction with their career choice as well as detrimental effects on family and social life\textsuperscript{20,22}. Those who are bullied or mistreated may themselves become bullies and perpetuate the cycle\textsuperscript{8,9,20}.

The experience of bullying, undermining, and harassment of fully qualified physicians also has significant consequences on the individual’s mental, physical and social health and potentially the provision of safe care. In one UK study of obstetricians and gynaecologists\textsuperscript{10}, impacts of workplace mistreatment by their physician colleagues were classified into four categories (coping, minor, moderate and major) based on 236 survey participant reports. Impacts included attempts to avoid the person doing the bullying, getting on with work “head down”, feeling demoralized, isolated, resigned to the situation, depressed, experiencing significant sleep disturbance, relationship and home life problems, reduced confidence, sick leave, thoughts of suicide, moving jobs, and early retirement.

In the general population, women who experience sexual harassment report a range of negative health and job-related effects. These include irritation, anxiety, anger,
powerlessness, humiliation, depression and post-traumatic stress disorder\textsuperscript{27}. In addition to these effects, studies from the United States report that women physicians and academic faculty members who experience gender or sexual harassment and discrimination may feel less confident in themselves as professionals, feel less in control of their work environment, have less satisfaction with their career choice, and report lower salaries and less career advancement than their male counterparts\textsuperscript{12,14}. Gender-based discrimination may be a significant factor in deterring women from enrolling in male-dominated specialties like surgery and in high female resident and physician attrition rates in these specialties\textsuperscript{28}. Such reports have prompted the National Academy of Science, Engineering, and Medicine to sponsor a study of sexual harassment in academia and its effects on women’s career advancement. Their report is due later this year. Recent news items identify similar problems for women in science and medicine in Canada\textsuperscript{29,30,31}.

As well, a number of reports acknowledge the critical role that intimidation, bullying, harassment and other disruptive behaviours play in the health care environment. A 2005 study titled: *Silence Kills: The Seven Crucial Conversations in Health Care* found that high rates of medication errors occur due to issues of interpersonal communication, many of which are related to disrespect and other forms of bullying\textsuperscript{20}. These behaviours undermine a culture of safety by disrupting trust and team cohesiveness, contributes to medical errors, adverse outcomes, poor patient satisfaction, increases cost of care and causes well-qualified professionals to leave health care organizations for other opportunities\textsuperscript{4,10,32}.

**Why does mistreatment/harassment persist?**

Given that IBH&SH and its negative consequences have been well-recognized in the medical literature for more than three decades, why does it persist? Recent review papers, joint commission statements and research studies provide some answers. First, the hierarchical structure of power in medicine and health care is long-standing and those on the lower end of clinical hierarchies are usually most vulnerable to mistreatment\textsuperscript{20,23,31}. Historically, the culture of medicine has displayed a tolerance and indifference to disruptive behaviour in clinical learning environments\textsuperscript{31}, with “disrespectful behaviour masquerading as necessary teaching methods”\textsuperscript{23}, hence the concern for medical trainees in particular\textsuperscript{20}.

As well, environmental factors contribute significantly to mistreatment. These factors include heavy workloads and increased stress, sleep deprivation and fatigue, poor work-life balance, and the often “high stakes/high emotion” situations that are a daily part of complex health care settings\textsuperscript{23}.
While hierarchy and power differentials can set the stage for mistreatment, it is silence that allows mistreatment to continue. The underreporting of various forms of mistreatment at all levels is well documented in academic medicine and health care settings, with reporting rates of 12% to 30% or even lower.

Silence exists for many reasons including the following:

- **Fear of reprisal or repercussion:** Because trainees and other physicians holding less power may be the target of harassment by more powerful senior physicians and mentors, they fear negative consequences on evaluations, residency placements and future training opportunities, or even job recommendations or promotion in the future. 
- **Fear that confidentiality will not be maintained and will lead to negative consequences.**
- **Stigma:** People fear being thought of by their peers, mentors, and colleagues as a ‘whistle blower’, of not being believed, of embarrassment of being the target of harassing behaviours.
- **Lack of knowledge or denial about what is mistreatment/abusive behaviour.**
- **Lack of knowledge about what policies and resources exist.** As one Canadian article noted, medical schools have policies and resources to deal with these issues under wellness programs or more formally through undergraduate medical education and postgraduate education offices, but trainees don’t know about them.
- **The hidden curriculum:** Throughout their medical education, undergraduate students and postgraduate residents are exposed not only to the formal curriculum, but also to the unspoken values, norms, and attitudes that are modeled by their mentors and teachers. This can be problematic when values and behaviours are in opposition to the espoused ethos of the profession (e.g., equality, respect, dignity) versus hierarchy, power, and dominance. The hidden curriculum can convey the message to learners that tolerating disrespectful behaviour is a necessary part of becoming a physician, a rite of passage. This can set up an inter-generational legacy of abuse. For example, results from the 2012 survey questionnaire of graduates from American medical schools found that residents were a primary source of medical student mistreatment thus perpetuating the cycle of abuse into the next generation. Likewise, in Canada, the 2016 graduation survey of medical school graduates reported that 34% of mistreatment behaviours came from residents.
Lack of trust in the organization’s ability to deal with it fairly and effectively - “nothing will change”⁶,⁹,²⁰,²⁶. Confidence in the organization is eroded when incidents are reported but no action is seen to be taken and the offensive behaviour does not change.

Proposed Solutions

Many of the papers in this literature review provide suggestions for tackling IBH&SH in medical schools and in health care settings. Suggestions tend to fall into the following major categories: education, policies/procedures, reporting, and culture change.

- Education/Awareness
  - Work with undergraduate learners, residents, faculty, and staff to define mistreatment in their unique cultural context⁴;
  - Develop curricula/modules for all learners, faculty and consultants on what constitutes IBH&SH, the impact of the behaviour, and what to do about it; more emphasis on the rights of trainees and responsibilities of faculty/supervisors²,⁹; involve trainees in the development of curricula on harassment²⁰; emphasize and model civility and humanism²²;
  - Provide training in areas such as communication skills, emotional intelligence, leadership skills, assertiveness, and conflict resolution in residency programs and for those supervising trainees at all levels²,²⁰,²³, especially residency program directors²⁰;
  - Partner with health authorities to train all HCPs in communication skills training and training in the recognition, management and prevention of workplace abuse²;
  - Communicate clearly about well-being resources available to learners and trainees and how to access them²⁰;
  - Emphasize team-based care at all levels of training programs²⁰;
  - Expose a hidden curriculum that perpetuates a culture of discrimination and mistreatment²²,³³;
  - Provide resident-as-teacher training that includes strategies for providing effective feedback, emotional regulation, and setting clear expectations for learners²³;
  - Develop formal preparatory training programs that clearly identify roles during periods when learners and trainees transition from one setting or level of training to another²³.
• Policies/procedures
  - Develop zero-tolerance policies and grievance procedures to ensure that all types of IBH&SH are reported and that all complaints investigated by a trained person with consequences clearly specified such as written reprimand, supervision, transfer, or dismissal\(^2,20\);
  - Implement policies at the point of learning and care by educators and those in authority to ensure timely resolution of complaints\(^8\);
  - Involve trainees in the development of policies on harassment\(^20\);
  - Develop policies that support flexibility in training and clear exit strategies for trainees being mistreated (e.g., leaving learning environments where trainees are being mistreated, change of residency program)\(^20\);
• Reporting/Processes
  - Develop mechanisms of ‘safe’ reporting that encourages people to come forward without fear of retribution\(^18\);
  - Create an anonymous reporting system and creation of a committee to review complaints, provide mediation and investigate bullying reports\(^20\);
  - Develop mechanisms to detect recurrent patterns of behaviour by specific individuals over time, even when victims are unwilling to file a formal complaint that would trigger a formal investigation\(^18\);
• Culture change
  - Develop a clear declaration of intent by medical school leadership to provide, maintain and support learning environments that are “rooted in respect for all patients, learners, teachers, and team members”\(^33\);
  - Create a culture of equity that is modeled by those with power and influence\(^19\);
  - Provide mandatory evidence-based explicit training about sexism and sexual harassment including information about reporting by bystanders\(^17-19\);
  - Create a medical training culture that emphasizes patient safety, teaching, team-based care, and the wellbeing of the organization’s members where feedback, new ways of thinking, and seeking help are encouraged and not seen as a sign of weakness\(^20\);
  - Develop a physician-in-training mentoring program\(^20\);
  - Work on implementing best practices and conduct ongoing evaluation/research to assess the effectiveness of these practices and interventions\(^34\).

In addition to these suggestions, two other documents provide an excellent starting point for discussion about how to handle issues of IBH&SH:
Unfortunately, time did not permit me to review the literature related to master’s and doctoral level students nor to administrative staff members who work in academic medical school environments. We do know, however, that mental health issues such as anxiety and depression are as much as six times higher in graduate students than in the general population and a supervisor who acts as a strong supportive mentor can positively impact students’ experiences of stress. We also know that workplace bullying and harassment of staff occurs in all work environments and contributes to lower levels of mental and emotional wellbeing, productivity and job satisfaction.

In summary, the body of medical literature reviewed on IBH&SH suggests that abuses are common across academic medicine and health care environments world-wide, including Canada, and that these behaviours persist despite concerted efforts by medical schools, residency programs, accreditation bodies, universities and health care institutions to eradicate it. Harassment behaviours in its various forms can have potentially far reaching effects on the health and professional lives of undergraduate learners, residents, and faculty/practicing physicians as well as impact quality of care. Behaviours persist due to an inter-play of power relationships and a web of societal, organizational and individual factors which mitigate against coming forward to report it and take action against it. Improving awareness and education, strengthening policies, procedures and reporting mechanisms and instituting broad culture change that supports respect and equity are suggested as ways to tackle the problem.
Literature Review References


31. Rodya C. CTV news. Doctor says she was suspended for reporting harassment. Feb. 21, 2018. [https://northernontario.ctvnews.ca/doctor-says-she-was-suspended-for-reporting-harassment-1.3805553](https://northernontario.ctvnews.ca/doctor-says-she-was-suspended-for-reporting-harassment-1.3805553).


Chapter Three: Medical Education Learners

Part A: Undergraduate Learners

Office of Undergraduate Medical Education and Office of Student Affairs

The Office of Undergraduate Medical Education (UGME) is responsible for all academic issues related to the four-year undergraduate program that leads to the Doctor of Medicine degree. Currently, there are approximately 316 undergraduate learners in the program. The first two years are mostly lecture-based classes and patient simulation experiences with some clinical observation experiences with practicing physicians. The third and fourth year learners are mostly in clinical settings in hospitals or health centres where learners function as clinical clerks. The UGME office is responsible for all academic program matters related to undergraduate learners; it provides various support services and coordinates educational activities throughout the program. The office works closely with the Program Evaluation Sub-Committee. The office is headed by the Associate Dean, UGME who reports directly to the Dean. Faculty matters related to teaching or supervising both undergraduate and postgraduate learners is normally the responsibility of the Chairs of the twelve clinical disciplines, the Vice Dean, or the divisional Associate Deans (Biomedical Sciences and Community Health and Humanities).

The Office of Student Affairs provides a range of personal, financial, academic and career counselling services and support for undergraduate medical students. The office has a full-time Student Wellness Consultant who is responsible for wellness programming and for responding to student concerns that impact academic or personal wellbeing. The Wellness Consultant collaborates with Memorial’s Student Wellness and Counselling Center on wellness programming and refers medical students as needed to these and other university or community-based services. There is a FOM Wellness Committee which addresses the needs of both undergraduate and postgraduate learners. The Student Affairs Coordinator organizes all the activities of staff in the office including monitoring and triaging anonymous student complaints submitted on-line. The Student Affairs office is headed by an Assistant Dean, Student Affairs who reports directly to the Dean. The Office has a confidentiality policy that ensures information will not be shared with others unless absolutely necessary or if requested by the student.

The UGME office and the Student Affairs office are arms length from each other and have no formalized reporting structure to each other. Accreditation standards mandate that student health and other personal matters need to be kept separate from the academic, evaluative arm of the program. The Associate Dean UGME and Assistant
Dean Student Affairs meet informally for discussion. It was reported that the two offices have good working relationships. However, because of the siloed nature of these two offices, there are instances when it is unclear what information is important to be shared.

**Accreditation Standards**

The Association of Faculties of Medicine of Canada (AFMC) monitors the quality of Canadian undergraduate MD programs through rigorous accreditation and quality improvement processes. Responsibility for maintaining accreditation standards falls under the umbrella of the UGME office, in conjunction with other units in the FOM. The Committee on Accreditation of Canadian Medical Schools (CACMS) and the Liaison Committee on Medical Education (LCME) have a number of standards which mandate that medical schools, universities and all affiliated sites are respectful environments, free from discrimination and student mistreatment.

**Standards for Accreditation of Medical Education Programs Leading to the MD Degree (2018)**

**3 Standard 3: Academic and Learning Environments**

A medical school ensures that its medical education program occurs in professional, respectful, and intellectually stimulating academic and clinical environments recognizes the benefits of diversity, and promotes students’ attainment of competencies required of future physicians.

3.4 Anti-Discrimination Policy

A medical school and its clinical affiliates do not discriminate on any grounds as specified by law including, but not limited to, age, creed, gender identity, national origin, race, sex, or sexual orientation. The medical school and its clinical affiliates foster an environment in which all individuals are treated with respect and take steps to prevent discrimination, including the provision of a safe mechanism for reporting incidents of known or apparent breaches, fair and timely investigation of allegations, and prompt resolution of documented incidents with a view to preventing their repetition.

3.5 Learning Environment

A medical school ensures that the learning environment of its medical education program is:
a) conducive to the ongoing development of explicit and appropriate professional behaviors in its medical students, faculty, and staff at all locations;

b) one in which all individuals are treated with respect. The medical school and its clinical affiliates share the responsibility for periodic evaluation of the learning environment in order to: a) identify positive and negative influences on the maintenance of professional standards b) implement appropriate strategies to enhance positive and mitigate negative influences c) identify and promptly correct violations of professional standards.

As part of the accreditation process and prior to the on-site visit by a six-member accreditation team, all enrolled students are asked to complete a questionnaire as part of an independent student analysis. A number of these questions ask about the learning environment (see below). Also, the accreditation team meets with groups of students to discuss both strong and weak points of the medical education program including issues related to a respectful learning environment and mistreatment.

Committee on Accreditation of Canadian Medical Schools Independent Student Analysis Survey

Questions on the Learning Environment

II. LEARNING ENVIRONMENT

Q 7-9 Reported under element 3.6

7. I am aware that my school has policies regarding the mistreatment of medical students. yes no

8. I know how to report mistreatment. yes no

9. I personally experienced mistreatment yes no

[described as any one of the following types: publically humiliated; threatened with physical harm; physically harmed; required to perform personal services, subjected to offensive, sexist remarks/names, denied opportunities or rewards based on gender, received lower evaluations or grades based on gender, subjected to unwanted sexual advances, asked to exchange sexual favours for grades or other rewards, denied opportunities for training or rewards based on race or ethnicity, subjected to racially or ethically offensive remarks/names, received lower evaluations or grades solely because of race or ethnicity rather than performance, denied opportunities for training or rewards based solely on sexual orientation, subjected to offensive remarks/names based on sexual orientation, received lower evaluations or grades based on sexual orientation rather than performance.]

Q 10-11 Reported under element 3.5 (vd=strongly disagree; d=disagree; s=agree; vs=strongly agree)

10. The medical school (and its clinical affiliates for students in years 3 and 4) fosters a learning environment in which all individuals are treated with respect VD D S VS
11. The medical school (and its clinical affiliates for students in years 3 and 4) fosters a learning environment conducive to learning and to the professional development of medical students.

From these documents, it is clear that the issue of respectful environments, student mistreatment including intimidation, bullying and harassment, and the timely response to these concerns is taken very seriously in accreditation reviews. The next date for accreditation for Memorial’s M.D. program is 2021.

**Reporting and Response to Issues of Intimidation, Bullying, Harassment and Sexual Harassment (IBH&SH)**

Undergraduate learners are able to report issues related to IBH&SH in one of four ways: Quality Reporting and Suggestion System (QRS), formal evaluations, informal conversation, and invoking established policies and procedures of the FOM or Memorial.

*Quality Reporting and Suggestion System (QRS)*

In 2015, the Office of Student Affairs established the QRS on-line anonymous reporting system for undergraduate learners. There are three ways to access the QRS Student Feedback form: Smartphone App, the FOM website under the ‘Students’ tab, and on the D2L course tab, however this last platform is not anonymous.

QRS is meant to capture both positive and negative comments in the learning environment. Students are asked to indicate on a drop-down menu the nature of their concern: curricular matters, health and safety, mistreatment, professionalism, positive recognition, student services, suggestions for improvement and any other issues students might wish to report. However, students can bypass this field and continue to the next box to describe their concern. This means that the Coordinator of Student Affairs must read and triage all messages and send them to the most appropriate person. Since 2015, more than 1300 reports have been submitted. It was reported that student QRS concerns are taken seriously and acted upon whenever possible.

The QRS system appears to be the primary approach used by undergraduate learners to report mistreatment or professionalism issues. In these cases, the Coordinator has to make a judgment call about who should receive the report – the Associate Dean UGME, and/or the Assistant Dean Student Affairs or another appropriate person. Currently, there is no process to clarify who should get these reports.
Associate and Assistant Deans and staff administrators reiterated that students want an anonymous reporting system like QRS. However, there a number of concerns with the current QRS system: a) anyone in the public as well as individuals in the FOM can submit a Feedback Form (although to date this is not believed to have been a problem); b) if serious, egregious concerns are raised about student mistreatment that need follow up, there is no way to trace the report in most cases to obtain more information; c) there is concern about due process for those accused of disrespectful/unprofessional behaviour.

*Formal Evaluations*

Anonymous on-line teaching evaluations of professors, course evaluations, preceptor evaluations, and evaluations of every rotation experience are available for every medical student to complete. These evaluations contain questions relating to respectful behaviour towards learners and others and additional anonymous comments can be added. Evaluations are tabulated and collated by the Health Sciences Information and Media Services Unit (HSIMS) which sends the aggregated data to the Medical Education Scholarship Centre (MESC) for distribution. Clinical preceptor evaluations completed in clerkships years three and four have a Red Flag/low performance rating system which identifies clinical faculty who have major concerns raised about them by students.

Aggregated data from teaching evaluations are sent to the faculty member and the administrative head. Because all courses are team taught, course evaluations are sent to the faculty in charge of that section of the undergraduate program. Red Flags are sent immediately to the Discipline Chair but no action is required unless three Red Flags are received. Normally, the faculty member and the Discipline Chair receive a copy of the aggregated comments once a year but only when a minimum of three evaluations are completed. Once three Red Flags are received, the UGME office is informed and action is taken usually by the Discipline Chair. Action may also be taken if there is a single egregious complaint.

No students I spoke with reported using evaluations as a way to inform the FOM about a faculty member or physician preceptor regarding a concern about IBH&SH. They reported being afraid the physician would know who the complainant was and that this might jeopardize their future career in some way.

*Informal Conversations*

There are a number of individuals in the FOM and at Memorial whom undergraduate learners can potentially contact to informally discuss issues of intimidation, bullying, harassment, and sexual harassment. These include individuals in the Office of Student
Affairs including the Student Wellness Consultant and the Assistant Dean; the Associate Dean UGME; and, trusted faculty or staff members. As well, some students may choose to discuss concerns with formally appointed student leaders. Ideally, learners would phone or meet directly with the Sexual Harassment Advisor in the Sexual Harassment Office to discuss any form of sexual harassment.

**Formal Policy and Some Issues**

There are a number of Memorial and FOM policies that are relevant to the undergraduate medical learner and the UGME and Student Affairs offices.

- **Memorial University Sexual Harassment and Sexual Assault Policy and the University-Wide Procedures for Sexual Harassment and Sexual Assault Concerns and Complaints.** The purpose of this policy is to ensure that all university members – students, faculty and staff – learn and work in an environment free from sexual harassment and assault. This pan-university policy and procedure is the responsibility of Memorial’s President through the Sexual Harassment Advisor. The policy and procedures clearly outline what constitutes sexual harassment and assault and approaches to methods to resolve concerns and complaints. It also encourages individuals to contact the Sexual Harassment Office (SHO) directly, as soon as possible after an incident has occurred, whether to oneself or as a bystander who observed or is aware of an incident of a sexual nature. However, if a student goes to a responder to report an issue of a gender or sexual nature (a trusted person), the responder must contact the SHO for advice, while maintaining the anonymity of the individuals involved (Article 1.3 of the policy). The SHO and Advisor provide education, anonymous consultation, confidential counselling and advice, and provide services to mitigate the effects of sexual harassment and assault. The Advisor assures that the entire process is complaint driven from the beginning, meaning that the complainant has the right to consult, to receive support and counselling, to make an informed decision, and has the right to withdraw a complaint at any time. The SHO has an excellent website with multiple supportive materials that are accessible and user-friendly. ([https://www.mun.ca/sexualharassment](https://www.mun.ca/sexualharassment)).

- **Memorial University Student Code of Conduct.** This policy applies to all students in all programs and addresses non-academic misconduct by a student on-campus, off-campus in some circumstances and by electronic means. There is a wide range of misconduct offenses detailed in the policy including bullying, intimidation, and harassment of various kinds. Sexual harassment is dealt with
through the *University-Wide Procedures for Sexual Harassment for Concerns and Complaints*. Possible sanctions that may apply to a student who is determined to have violated the Code are clearly outlined. The procedure for informal and formal resolution is described along with an appeals procedure. The policy is under the auspices of the Student Code of Conduct Officer and Complaints Coordinator. An important point is that all faculties, departments and schools are encouraged to resolve student misconduct matters informally, at the local level, whenever possible assisted by various university offices and resources. As a reader of this policy, it was unclear to me whether this last statement implies this policy should be used by the appropriate administrator in a given faculty, school or department as a mechanism to achieve an informal resolution.

- **Respectful Learning Environment Policy for Medical Education.** This policy is based on Memorial’s *Respectful Workplace Policy* and outlines the expectations, guidelines, and processes that support a learning environment free from intimidation and harassment that can be invoked by undergraduate and postgraduate learners in the FOM. The policy outlines an informal approach to the early resolution of a concern and a more formal written complaints process. If an undergraduate student wishes to use this policy, the formal contact is the Office of Student Affairs. Student Affairs reported that this policy has worked well in the early resolution of concerns brought forward by undergraduate students.

- **Statement of Professional Attributes and Process for Addressing Breaches of Professionalism by Undergraduate Medical Students.** From the very beginning of their entry into medical school, undergraduate students are expected to demonstrate professional behaviours regarding respect for others, honesty and integrity, compassion and empathy, and responsibility and duty. This expectation is clearly described in the *Statement of Professional Attributes* policy. If an undergraduate medical student is believed to display unprofessional behaviour, two reporting processes are outlined: one for those who teach, assess or provide feedback for the student and one for other observers such as students, other faculty, staff or the public. In the latter case, the observer completes a *Professionalism Concern Form* which is sent to the Associate Dean, UGME who contacts the appropriate faculty lead to meet with the student to discuss the issue. The bottom of the *Form* contains a footnote stating that concerns related to intimidation and harassment should be dealt with using the *Respectful Learning Environment Policy for Medical Education*. 
Office of Student Affairs, Faculty of Medicine, Confidentiality Policy. This policy seeks to assure students that their privacy relating to personal, financial, academic and career concerns are kept in strict confidence and will only be shared by others outside the Student Affairs office with the express consent of the student. The only time confidential information will be shared include the following: to protect the student or others from physical harm; the legal obligation to report child abuse; imminent danger to the community-at-large; and, a court subpoena. Administrators in Student Affairs told me that this policy dictates all actions taken by the Office.

Student Experiences and Reporting of IBH&SH

Two male students came forward to share their positive experiences of the learning environment. Both reported that the FOM’s faculty and staff and all clinical experiences have been respectful of them as individuals and supportive of their learning. They felt they were encouraged to bring forward any issues of concern during their program. One student wrote: “I wouldn’t have changed anything about the learning environment over the last four years”.

Six female and two male students came forward to share their experiences of sexual harassment and other bullying or intimidating behaviour either as a target of the behaviour or as a witness to the behaviour. Students described experiencing the following:

- multiple instances of gendered, sexist comments by peers during clinical skills sessions, during other academic and social situations, and over social media;
- inappropriate, gendered comments by a patient during a learning situation towards a group of five female students. The male physician faculty member was reported to have “played along” with the patient rather than correct the inappropriate comments;
- a few stereotypical negative comments about some ethnic groups made in class;
- instances of inappropriate gendered comments by a physician during an extended clinical learning experience made when alone with the student and in the presence of patients;
- unwelcoming or exclusionary behaviour by peers that impacts on full participation in some medical school activities and social gatherings;
• pressure tactics by peers to participate in fund raising events that can cause additional stress;

• undue pressure by peers to make a change in a rotation that would benefit the other students;

• witnessing what is believed to be gender bias displayed by some professors and physicians when male students are treated differently from females (e.g., arriving late for class – males are excused but females are not; females being told that they should not go into some surgical specialties if they want to have a family);

• witnessing a senior resident arguing with a junior resident in front of nursing staff and then belittling the junior resident during Rounds in front of colleagues and clinical clerks;

• witnessing bullying of more quiet, reserved students by peers including student leaders who:
  o criticize individuals on social media
  o display unprofessional behaviour regarding the application process for clerkship rotation slots; this sets up a hostile, secretive, competitive environment and impacts collegiality in the class.
  o discuss issues, brought to a student leader in confidence, with a small group of friends within earshot of other students.

Other Reports of IBH&SH toward Undergraduate Learners

• One former part-time faculty member reported witnessing or being told by medical students about behaviour related to gender inequity and other negative learning experiences in their medical education program. These reports occurred during the period 2012 to 2017. Examples include the following: male faculty undervaluing the practice of family physicians and suggesting that it was suitable for “part-timers especially women”; male faculty rapidly questioning and interrupting female students giving a presentation but treating male students with greater respect; female clinical clerks being told to get the coffee for everyone but the same was not requested of male clinical clerks; a female clinical clerk who expressed interest in a surgical career was told it is too stressful - she looked more like a family doctor - and besides she might be a “distraction” in the operating room. Students also reported to this former faculty member that while there was student representation on many FOM committees, their suggestions
were often given the “silent treatment”. They reported feeling that there was no real consultation on new policies or explanations about why policies were changed. This former faculty member expressed concern about the lack of meaningful response to these issues by the administration and believes that students and faculty members are afraid to report such incidents for fear of damaging their own careers.

Impact

Students reported that being the target of sexual harassment made them feel: uncomfortable to come to class or other learning activities; personally threatened in some instances; and, wary of being alone with the person(s) who was the source of the behaviour. Students who felt excluded or unwelcomed from activities or unduly pressured to participate in fundraising or to change their program reported feeling stressed, upset and uncomfortable with their peers. Individuals who reported witnessing sexist, intimidating or other inappropriate behaviours reported feeling uncomfortable and unsure of what to do.

A number of students stated that they had reported instances of sexual harassment and intimidating behaviours to individuals in the FOM Office of Student Affairs and the UGME office using informal discussion, one or more FOM policies, or the QRS reporting system. Those experiencing sexual or gender harassment reported that they were not initially advised about the Sexual Harassment Office or the pan university Sexual Harassment Policy when they first reported these incidents. They believed that reporting their concerns to the appropriate officials in the FOM would trigger action to stop the behaviours from reoccurring. From the perspective of the students, no action was believed to have been taken.

When action is not seen to be taken against a perceived injustice, students reported:

- a lack of faith in the current system to handle issues of intimidation, bullying, harassment and sexual harassment;
- a belief that individuals who are the source of harassing behaviours are often protected at the expense of those who are the targets of the behaviour;
- the “rumour mill” is allowed to flourish impacting collegiality;
- those who report harassment are ignored “in the worst way” and “silenced”;
- sexual harassment has a chilling effect on women in medicine generally;
• the lack of action sends a message that the social and psychological safety of female medical students is less important than general male misconduct;
• feeling sad to think of the unwelcoming message this sends to female medical students;
• questioning the way professionalism is viewed - that not attending class or being late - is a professionalism issue, but serious harassing behaviour of a student colleague – nothing is done or seen to be done.

Culture within the FOM and Actions to Date

There was a decided split in student opinion about the culture in the FOM. A few male students felt there was not a culture of intimidation or harassment at all. Most other students reported that while there was not an explicit culture of intimidation and harassment and sexual harassment, they believed that no action would be taken against these behaviours. One student noted: “there is not a good way to deal with these things”. One student reported that many students seem scared and shy and would be afraid to report issues of intimidation and harassment. A few female students and one male student felt there was a culture of intimidation and harassment that was elitist and protective of certain people. One male student believed there was institutional gender inequality. The former part-time faculty member also described the learning environment as negative with overtones of gender discrimination.

Past and current administrators in the UGME and Student Affairs office reported that while the culture in the FOM is not perfect, they do not believe there is a pervasive culture of intimidation and harassment. It is thought to be a generally respectful environment. One administrator expressed a concern that intimidation and harassment is very likely underreported in the clerkship years.

In terms of policy, one administrator noted that past efforts to develop processes around intimidation, harassment and professionalism issues have been done in a piecemeal fashion. However, in May 2017 a Professionalism Working Group was struck to take a broader, holistic perspective of the issues. The group is chaired by the new Associate Dean, UGME. The working group has been working on: a) a formal overarching professionalism curriculum that would encompass undergraduate, postgraduate and continuing professional education; b) a policy review and development that would provide clarity in reporting, reduce redundancies, and align FOM policies with Memorial’s policies; c) development of an anonymous, confidential reporting system for professionalism complaints; and d) development of a standardized, transparent,
consistent intervention plan to address issues of unprofessional behaviour so that everyone understands what action will be taken. A draft report has been completed and is awaiting implementation pending release of this unit assessment report.

**Part B: Postgraduate Learners (Residents)**

**Organization of Postgraduate Medical Education**

The Office of Postgraduate Medical Education (PGME) is responsible for approximately **280 post graduate learners**, also called residents, in 18 disciplines or residency training programs in the FOM. These programs are: Anatomical Pathology, Anesthesia, Diagnostic Radiology, Family Medicine (with an enhanced third year in Enhanced Skills/Emergency, Care of the Elderly, and Care of Underserved Populations), General Surgery, Orthopedic Surgery, Internal Medicine, General Internal Medicine, Nephrology, Neurology, Medical Oncology, Obstetrics and Gynecology, Pediatrics, and Psychiatry (with a subspecialty in Child & Adolescent Psychiatry). A focused competence program in surgical skills is also offered. Program size varies considerably from a low of a few residents to 70 residents in a program. Program length also varies from 2 to 5 years.

Each of these disciplines has a Program Director who is a practicing physician in that specialty or subspecialty and a FOM clinical faculty member. They hold the chief responsibility for all academic and clinical experiences of residents in their program. Program Directors report directly to the Discipline Chair (also a FOM clinical faculty member and a practicing physician) who in turn report directly to the Dean of Medicine. Discipline Chairs are overall responsible for the faculty who teach residents, and engage in clinical research as well as oversee the use of funds in their program. As well, Eastern Regional Health Authority, known as Eastern Health, appoints a Clinical Chief for all specialty service units. In some residency programs, the Discipline Chair is also the Clinical Chief of the service.

Discipline Chairs meet regularly with Program Directors. The Associate Dean is the head of the PGME office which provides support, advice and direction to Program Directors, Discipline Chairs, and residents. The Postgraduate Education Committee which includes the Associate Dean and all Program Directors meets quarterly. Once a year the Discipline Chairs also meet with the committee.

The Associate Dean of PGME has an open door policy and frequently meets informally with Program Directors and Discipline Chairs in person or by email and meets formally with each Program Director yearly. The Associate Dean also meets with many residents and asks about issues relating to intimidation and harassment.
Accreditation Standards

The Associate Dean of PGME has overall responsibility for the quality of the 18 residency programs and, with other members of the leadership team including Program Directors and Discipline Chairs, makes sure that all programs conform to the accreditation standards of the Royal College of Physicians and Surgeons of Canada (RCPSC) and the College of Family Physicians of Canada (CFPC). Both accreditation bodies have a number of standards which mandate that universities, affiliated sites and all residency programs be free from intimidation, harassment and abuse.

Royal College of Physicians and Surgeons of Canada Standards (RCPSC) (2013)

**A3.** “The faculty post graduate medical education committee and/or its subcommittees thereof, must oversee all aspects of postgraduate medical education”.

**A3.7:** “The committee must ensure a proper educational environment free of intimidation, harassment and abuse with mechanisms in place to deal with such issues as they arise”.

General Standards applicable to all residency programs

**B3.9:** “Teaching and learning must take place in environments which promote resident safety and freedom from intimidation, harassment and abuse”.

General Standards for areas of focused competence program (2011)

**C3.6** – “Teaching and learning must take place in environments which promote trainee safety and freedom from intimidation, harassment and abuse”.

The College of Family Physicians of Canada (CFPC) (2016)

The Learning Environment

**B3.5.** “The program must provide a learning environment that is safe and supportive of its residents. Faculty-resident interaction and communication must occur in an open and collegial atmosphere, such that the tenets of acceptable professional behaviour and the assurance of dignity in the learning environment are maintained at all times.”

**B3.6.** “Discussion about the strengths and weaknesses of a program must occur freely and in a manner that is without repercussions to residents. An accessible and non-threatening mechanism must be in place to ensure that allegations of unprofessional behaviour hindering the learning environment can be investigated impartially. Program
directors, faculty, other teachers, and residents must be educated about appropriate behaviour in the learning environment and specifically against intimidation and other abusive behaviour."

As well, both accreditation bodies use the same six-page document titled: *Accreditation and the Issue of Intimidation and Harassment in Postgraduate Medical Education Guidelines for Surveyors and Programs* to instruct accreditation teams on how to assess whether standards are met. The teams meet with residents as part of their assessment and ask very directly about issues related to harassment and intimidation. These standards are being rewritten in Canada and will be even more rigorous according to a recent article in the Canadian Medical Association Journal.

**The Status of Postgraduate Learners (Residents) at Memorial**

Postgraduate learners in the FOM are considered full-time students of Memorial University of Newfoundland and of the FOM but are not graduate students (Section 8.3, Memorial University of Newfoundland Calendar). All residents are also full-time employees of Eastern Regional Health Authority and provide patient care services for which they are paid. Therefore policies of Memorial, the FOM or the health authority may apply to residents depending on specific circumstances. The Professional Association of Residents in Newfoundland and Labrador (PARNL) acts on behalf of all residents in negotiating salaries and benefits with health authorities and advocates for educational, professional and wellbeing issues.

**Reporting and Response to Issues of IBH&SH**

Residents are able to raise concerns about unprofessional/disrespectful behaviour in one of three ways: formal evaluations, informal conversation, and invoking established policies and procedures of the FOM, Memorial, or the regional health authority.

**Formal Evaluations**

Anonymous on-line faculty evaluations and evaluations of every rotation experience are available for every resident to complete and contain questions relating to respectful behaviour towards learners and others. These are sent directly to the Health Sciences Information and Media Services Unit (HSIMS), a trusted third party, who tabulates and collates responses which are then sent to the Medical Education Scholarship Centre (MESC) for distribution. A Red Flag/low performance rating system identifies faculty who have major concerns raised about them. Red flags are sent immediately to the Discipline Chair but no action is required unless three Red Flags are received. The faculty member and the Discipline Chair receive a copy of the anonymous collated comments
usually once a year. However in programs with small numbers of residents, there may be a lag time of two or more years because a minimum of three evaluations must be completed before comments are collated and distributed. If a single serious Red Flag is received, however, the Discipline Chair may contact the faculty member immediately for discussion and also direct the Red Flag to the Associate Dean. Residents also have exit interviews and an opportunity to complete an exit survey that asks about intimidation and harassment.

A number of residents reported that while faculty evaluations are “theoretically” anonymous, they have strong concerns about confidentiality for two reasons. First, the on-line evaluations are tied to their individual email and they believe are potentially traceable back to them. Second, the cohorts in many residency programs are small and if someone reports intimidation or harassment, the faculty staff physician may be able to surmise who the complainant is. For example, residents reported to one Program Director that they were intimidated by staff physicians after giving negative feedback on what was thought to be an anonymous formal evaluation.

According to several administrators, there are few tools to handle issues of intimidation and harassment by a faculty member except for collegiality and conversation. When harassment issues are raised in evaluations, the usual approach is for the Discipline Chair to discuss the issue with the faculty member and ask them to write a reflective piece about the behaviour which is put in their file.

Informal conversations

There are a number of individuals whom residents can potentially approach to discuss issues of intimidation and harassment informally. Depending on the size and structure of their residency program, these individuals may include the Program Director, the assigned faculty advisor, the president of their residency year, the stream head in the case of Family Medicine, or they may go directly to the Associate Dean of PGME. Most programs also have monthly residency program committee meetings where issues of concern can be discussed.

There are also two Postgraduate Wellness Counsellors available to all residents. The Wellness Counsellors are arms length from PGME and have no conflict of interest with the residency programs. This is assured by assigning one counsellor, a member of the College of Family Physicians (CFPC), to meet with residents governed by the Royal College (RCPSC) and the second counsellor (a member of RCPSC) to meet with residents governed by CFPC. These positions have a wellness focus with most residents contacting them for career advice, family or work-related stress, or general anxiety. The
Wellness Counsellors are well equipped to handle counselling on these matters and are able to refer residents to other services such as the Memorial University Counselling Centre, the Employee Assistance Program, etc. when required. They are also available to help with issues of intimidation and harassment. (See policy section below).

Residents who met with me reported that if an issue of intimidation or harassment arose and they felt comfortable to report, they would likely go to a known and trusted person often the Program Director. When a concern or complaint is brought to their attention, Program Directors attempt to deal with it informally but it all takes time and extra work. In addressing the concern, one Program Director reported that they would meet with the resident, call in the preceptor, review the policies, call for and review preceptor evaluations, deal with the impact on other learners, and try to figure out who gets notified and what to do about it. As one Program Director stated: “What actions are even possible”? This comment was echoed by a number of residents and administrators I spoke with. However, if the complaint of intimidation is with the Program Director or the Discipline Chair, one resident believed that “there is no ‘safe’ place to report”.

Formal Policy

According to the PGME office, residents are introduced to the FOM’s 2014 Respectful Learning Environment Policy for Medical Education during orientation to their program; they receive a copy of the policy and procedures and are directed to the FOM website where the policy is accessible anytime. As well, Program Directors are encouraged to discuss the policy with residents. However, not all residents who came to meet with me knew about the policy. If residents decide to use the policy to register a concern or complaint about intimidation or harassment, the formal contact person for residents is the appropriate Postgraduate Wellness Counsellor for their program.

Both PGME Wellness Counsellors are familiar with the Respectful Learning Environment Policy and with Memorial’s Sexual Harassment and Sexual Assault Policy. One counsellor reported that no concerns about harassment of any kind had been reported over many years in the position and the second counsellor noted that recently one resident had sent an email about harassment but the individual had not followed up.

In discussing their role as the “advisor” in the Early Resolution of Concerns in the Respectful Learning Environment Policy for Medical Education, one counsellor felt the policy lacks detail and guidance for the advisor. There are no specific guidelines on how to proceed or who to include or seek advice from at different stages of the process. As well, the counsellor felt they did not have the authority to talk to other medical faculty
whose behaviour may be of concern or have any decision-making authority to resolve the situation informally. While the counsellors are skilled at individual and family counselling, they do not have formal training in mediation of intimidation/harassment issues or workplace conflict resolution.

The PGME office reported that the Respectful Learning Environment Policy for Medical Education had been invoked at least once since 2014 and a number of issues were identified including the need to inform all parties about the final decision of a formal complaint and the lack of a process to appeal the decision.

As well, other policies relating to harassment of a resident when the source of the behaviour is a non-Memorial employee would be available through the regional health authority. However, no resident reported having used this policy.

Reasons for Not Reporting

While there are potentially a number of ways available for residents to report intimidation or harassment as individuals, it appears that many residents do not feel safe to do so. Residents reported concerns about confidentiality, fear of immediate or future retaliation, and being labelled as a “complainer.” Residents are concerned about the potential impact on their future employability and future professional relationships with staff physicians who will soon be their colleagues once their training is complete. Residents reported that the small medical community in Newfoundland and Labrador heightens these concerns for those who want to live and work in the province. As well, they do not report because they do not see good outcomes when they do complain. The reasons for maintaining silence that I heard from residents are much the same as those reported in the medical literature (see Chapter Two).

Residents may feel safer reporting issues of harassment in a group context, for example when they meet with accreditation teams or individuals perceived to be impartial. Clearly, this is a major concern for residency programs and the FOM when these issues have not been addressed and accreditation status is in jeopardy.

Experiences with IBH&SH, Impact and Other Issues

- Five residents, one practicing specialist physician, and one administrator\(^1\)* describe either being the target of intimidation or harassment, being a witness to it, or having heard of these behaviours by staff physicians/preceptors toward other residents or clinical clerks. Examples include: being ridiculed in front of colleagues; being on the receiving end of belittling comments made in front of colleagues;
health care staff; being yelled at; being the target of overly critical comments that were not constructive; being “picked on” and persistently singled out; being told not to call the attending physician with patient concerns and when they do call, being sworn at over the phone; having to handle clinical situations beyond their skill set because the attending physician would not answer their phone or pager; hearing about a threatening situation of sexual harassment a number of years ago by an attending physician towards a resident; being the object of personal comments about race or body size. One resident reported witnessing disrespectful, gender-biased comments by hospital staff towards female residents compared to male residents.

- The impact of all these behaviours on residents was described as distressing, disturbing and personally upsetting. They reported that these experiences can undermine confidence and promote a feeling that “no one has your back.” Another resident identified other negative consequences of intimidation and harassment including overall health and wellbeing of residents and their families, absenteeism, and patient safety.

- Two administrators noted that the FOM is still too siloed. For example, clinical clerks and residents rotate through many departments where disrespectful behaviour might occur, but information about such behaviours is not shared so that action could be taken.

- Another administrator noted that there are long-standing issues related to the interface of the FOM with Eastern Health. There is no formal process to discuss concerns about intimidation/harassment related to individuals who are faculty in the FOM and also working at Eastern Health or other health authorities.

**Culture within the FOM**

Most residents and administrators do not feel there is a pervasive culture of intimidation, harassment or sexual harassment in the FOM. Many feel that “most people are great”. However, most believe there is a culture of tolerance for harassment by certain individuals and in some residency programs. The perception is that these individuals are not held accountable for their bullying, intimidating behaviour. Administrators reported that they have taken action over the past year to meet and discuss issues with faculty identified as the source of the behaviours and more recently have taken stronger structural action in response to concerns raised in accreditation reports and by residents. In their view, there have been improvements and more
engagement by faculty to deal with these issues. However they acknowledge that there are still some ongoing concerns.

One resident who was not a graduate of Memorial’s undergraduate medical school program felt that the work and learning environment was border-line intimidating and felt unwelcoming.

Three residents discussed culture within the context of the “hidden curriculum”. They described a number of “unstated” messages that were contrary to the stated values of the FOM (e.g., women can’t be surgeons; long work hours – “first in, last out”- is what is valued; and, family medicine is not as respectable as other residency programs and is on the lowest end of the power hierarchy).

**Suggestions Proposed by Medical Education Learners and Administrators about IBH&SH**

During my discussions with learners and administrators, I asked individuals for their thoughts on what would help improve the reporting and response to IBH&SH and what would improve the culture in the FOM.

**Reporting**

**Undergraduate Suggestions**

- Develop processes for reporting issues of intimidation and harassment that are transparent and fair to all parties especially those who come forward to report concerns.
- Clarify and name the possible consequences of intimidating, harassing behaviours.
- Develop a process to provide feedback to students who have come forward with a concern. Right now, no one knows what action was taken, if any.
- Consider anonymous reporting instead of having to sign a complaint form in order for action to be taken.
- Institute a safe place to report and talk about the issues.
- Appoint a Harassment Officer who will work though issues with students.

**Postgraduate Suggestions**

- Develop a transparent process for reporting concerns and complaints about intimidation, bullying and harassment that identifies actions, resolutions and
sanctions. Need to close the loop so that all parties are aware of the outcomes. Right now, no one knows what happens if a concern is reported.

- Establish an anonymous, Red Flag system to report intimidation, bullying and harassment that is not ‘formal’ but needs to be investigated and action taken.
- Appoint a central “ombudsperson” who has the expertise and authority to investigate all Red Flags and other complaints and be a resource to residents, Program Directors, and PGME Wellness Counsellors.

Survey

Undergraduate Suggestions

- Conduct an anonymous on-line survey of all medical students on the topic of intimidation and harassment.

Communication

Undergraduate Suggestions

- Clarify what is meant by a zero-tolerance policy for sexual harassment in the FOM? What is the threshold for harassing behaviour?
- Provide clear definitions and behavioural criteria about ‘professional’ behaviours that cover intimidation and harassment.
- Significantly improve the communication of policies and reporting about student mistreatment. Design one-page intimidation & harassment info-graphic (flow chart) that clearly guides the student in decision-making about which policies are appropriate to address a particular type of behaviour, what is the best option, who to contact, etc. These one-pagers could then be well displayed in classrooms, other academic spaces, student social spaces, etc.

Postgraduate Suggestions

- Develop and implement processes to normalize discussion about intimidation and harassment across residency programs. For example, before rounds, have a debrief session with residents and clinical clerks about harassment, respect, and ethics.
- Improve printed and on-line residency program and clerkship handbooks so that information about intimidation and harassment is upfront.
Education

Undergraduate Suggestions

- Develop mandatory education sessions about intimidation and harassment in all its forms that includes videos of scenarios and skill building. Currently, learners reported they only have one session on the Respectful Learning Environment Policy.

- Formal education needs to be provided in orientation and at regular intervals over the four years related to IBH&SH. Needs to be integrated into the culture of the FOM for all students, faculty and staff.

- Establish a ‘boot camp’ on IBH&SH issues before clerkship.

- Clarify the role of medical school student leaders and provide leadership training for student leaders.

Postgraduate Suggestions

- Develop, implement and evaluate education and training about the issue at all levels. Education needs to begin early in undergraduate training, ideally including all health profession students (i.e., Interprofessional Education blocks).

- Develop a workshop on IBH&SH to be given to all residents during Academic Half Days.

- Take pro-active steps such as inviting staff from Memorial’s Sexual Harassment Office and others expert in bullying and intimidation to give a session to residents in individual programs. Issues may present differently in different contexts.

- Discuss development of an on-line education module on IBH&SH with the RHAs that would be an RHA requirement for every employee and learner. (One example is a mandatory module required by the University Health Network in Toronto).
  http://www.uhn.ca/corporate/AboutUHN/CEO_Straight_Talks/Pages/update_workplace_harassment_policy.aspx

- Develop tools that actively engage faculty in reflection about issues related to IBH&SH. Examples are a professionalism mentoring program, development of seminars on topics such as stress management, anger management, etc.
• Institute leadership training for Program Directors and Discipline Chairs and empower Residency Program Committees to deal with these issues on the ground and resolve issues early.

Wellness

Undergraduate Suggestions

• Provide enhanced training in empathy so that students are more understanding of each other.

• Promote more inclusive social functions that are welcoming for all medical students.

Postgraduate Suggestions

• Promote a more welcoming environment for all residents especially those who are not Memorial medical school graduates. This could include more planned family-related social events for residents across all programs and years.

• Empower Resident Wellness Committees.

Clarify Roles and Responsibilities

Postgraduate Suggestions

• One administrator explained that residency programs are in a time of change with the introduction of the “competency by design” approach to learning. Therefore, this is an ideal time to clarify the expectations of everyone’s roles and responsibilities - staff physicians and residents alike. Because residents are employees of the regional health authority (RHA), RHAs need to develop job descriptions to clarify the employer’s expectations of postgraduate learners at different stages of training.

In support of this idea, a second administrator reported that one residency program had no issues with harassment because everyone “knows their role”. This comment was reiterated by a junior resident who stated that no one in a senior capacity had sat down and clarified expectations of his work role as a resident and provided direction on how to meet those expectations. The resident further added that this lack of clarity was problematic in what should be a “high reliability” organization. This resident and others reported that that clear expectations at every level of residency training would reduce stress for residents
and potentially reduce conflict situations that might trigger disrespectful behaviours.

Part C: Discussion and Recommendations

Building Trust and Confidence

My discussions with undergraduate and postgraduate learners suggest that some learners have lost faith in the ability of the FOM to deal effectively with issues of IBH&SH. Administrators reported that systems are not working optimally at the present time and changes are needed. This was reiterated by faculty and administrative staff I spoke with as described in later chapters of this report. The following set of six recommendations is based on suggestions by learners, faculty members and administrative and other staff members as well as from the literature review.

Recommendations

In order to regain the trust and confidence of all learners, faculty and staff in the Faculty of Medicine (FOM) and assure accountability, I suggest the following recommendations.

1. As soon as possible, the Dean FOM and senior leadership of Memorial University release a strong statement reaffirming their commitment to providing a respectful learning and work environment free from intimidation, bullying, harassment and sexual harassment for all learners, academic and clinical faculty members and administrative and other staff members. If this includes a commitment to zero tolerance, it is important to clarify what that means. Providing examples of the kind of culture the FOM wishes to create will be important to include. The statement should describe the specific measures to be taken to meet these goals.

2. An anonymous on-line survey on intimidation, bullying, harassment, sexual harassment and the perceived culture in the FOM be developed and distributed to all learners, academic and clinical faculty members and administrative and other staff members. Provide an opportunity for survey respondents to describe how they define mistreatment/disrespect in their learning and working environments. This will provide more input about the issues from those who felt unsafe to participate in the unit assessment. It will also provide information about the scale of the problem and a baseline from which to regularly evaluate the impact of interventions. (My understanding is that the Professionalism Working Group has begun work on a survey of this type already).

3. An accountability framework and process be established to: monitor the implementation of measures taken towards an enhanced respectful environment;
evaluate how the measures are working; and, determine changes needed for continuous improvement. As suggested in the literature, this process could be part of a research project to evaluate best practices. This is an area that has had little systematic study.

4. A Respectful Environment Working Group(s) with representation from undergraduate learners, postgraduate learners, graduate students, academic faculty, clinical faculty, permanent staff members, contractual staff members, administrators and appropriate others including the Sexual Harassment Advisor (or designate) and a representative from Eastern Health be established to have input into the development of the accountability framework and process and be convened on a regular basis to receive reports on ongoing progress.

5. The Respectful Environment Working Group will establish the essential elements of mandatory training on IBH&SH that are required by all learners, faculty and staff members in the FOM. Modules, workshops or other mechanisms will be developed and delivered on a regular basis.

6. An accountability progress report issued from the Dean’s Office be published at regular intervals (e.g., twice a year) on issues related to a respectful workplace and the culture of the school. Submissions from all constituencies in the FOM should be encouraged for inclusion in the report.

Policy Issues

As one FOM administrator pointed out, the past efforts of the FOM to develop policy and processes addressing intimidation, harassment, and professionalism issues have been done in a piecemeal fashion. This was evident in my discussion with learners and administrators and in my own review of the policies. However, a comprehensive review of all FOM policies related to mistreatment/harassment and professionalism will require adequate time to develop.

Therefore, policy recommendations are presented in two parts: short-term and long-term recommendations. The first part presents recommendations for revision of current policies in the FOM to better alignment them to policies of Memorial University. In one case, I suggest considering a change to the Memorial policy as well. These revisions or clarifications should be able to be implemented relatively swiftly. The second set of recommendations regarding FOM policies takes a longer-term view of policy change and will need more time for discussion and input. (Please note that policies specific to graduate students, faculty members, and administrative/research staff are in later
chapters). I also need to reiterate that I am not an expert on policy so some of my suggested recommendations may not be appropriate.

**Short-term Policy Recommendations**

To improve and update policies as they currently exist, I suggest that the FOM and Memorial review the following policies as soon as possible and make revisions as appropriate:

7. FOM Respectful Learning Environment Policy for Medical Education and Memorial’s Respectful Workplace Policy

There are a number of issues with regard to these policies as currently written.

- **First:** Under the introduction to the *Respectful Learning Environment Policy* under “Purpose” and “Scope”, a statement could be included to clearly indicate that all issues related to gender or sexual harassment should be dealt with through *Memorial’s University Sexual Harassment Policy and the University-Wide Procedures for Sexual Harassment Concerns and Complaints*. This statement is included in the *Respectful Workplace Policy* under “Scope”.

- **Second:** Under the Procedure for Early Resolution of a Concern, Article A.1.5.2 in the *Respectful Learning Environment Policy* and Article 8 in the *Respectful Workplace Policy* both state that there will be a discussion of the Concern with the parties involved, with the goal of reaching a mutually acceptable resolution. A number of individuals believed that the discussion of the Concern would need to occur with both parties sitting down together. They reported this belief was an impediment to even considering using the policy to address an issue of intimidation and harassment because they would not want to discuss the Concern with the Respondent directly. Rewording these articles to reflect possible options for discussing the Concern would clarify this issue.

- **Third:** There is no procedure to appeal a decision of a formal complaint in the *Respectful Learning Environment Policy*. An appeals process is included in the *Respectful Workplace Policy*. Addressing this issue will require deciding who should receive the initial investigation report in the first instance (e.g., the Vice Dean?). This would leave the Dean available to hear an appeal.

- **Fourth:** In the Procedure for the Resolution of a Formal Complaint, Articles A.2.11 and B.3.2.2.3 in the *Respectful Learning Environment Policy* and Article 11 in the *Respectful Workplace Policy* indicate that notification of an action to be taken (e.g., discipline) will only be communicated to the Respondent within 5 working
days of a written decision. But there is no provision to communicate with the respondent if no action will be taken. In a recent reported case in the FOM, the Respondent was unaware that no action would be taken about a complaint and so continued to be stressed and anxious because he/she had not received any communication about the final decision. Modifying the statement to include that the Respondent will be notified of the decision to impose discipline or not would alleviate this concern for Respondents.

- Fifth: Another concern with regard to the above notification of discipline of a formal complaint is why the Complainant is not notified if action will be taken or not. Many individuals who had reported concerns in the past (not necessarily with this policy) talked about being frustrated that the ‘loop wasn’t closed’ – they never knew if any action had been taken. This lack of closure is seen as problematic and reinforces the belief that nothing is done. While privacy may be a concern for the Respondent, some way of letting the Complainant know that action is being taken seems reasonable especially given that many Complainants feel they have put themselves on the line to report.

8. Statement of Professional Attributes and Process for Addressing Breaches of Professionalism by Undergraduate Medical Students and the Professionalism Concern Form.

The bottom of the Professionalism Concern Form contains a small footnote stating that concerns related to intimidation and harassment should be reported using the Respectful Learning Environment Policy for Medical Education. However, the footnote is not prominently displayed and would be easy to miss by a reader. In the short term, I suggest that the wording about reporting intimidation and harassment using the Respectful Learning Environment Policy for Medical Education be prominently displayed at the top of the form along with a statement that if the concern relates to sexual harassment, the appropriate policy is Memorial’s Sexual Harassment Policy.

9. Confidentiality Policy

The confidentiality policy does not indicate to learners that the Student Affairs Office is obliged to consult with the Sexual Harassment Advisor for advice in circumstances when a learner reports sexual harassment. This will not violate student confidentiality since no names will be revealed when seeking the advice without the student’s permission. This policy was established in 2011, and so needs a full review including the issue I raise here about sexual harassment concerns.
General Comment About Policy

There is one general point about the FOM and applicable Memorial policy documents that arose in discussions. Individuals perceive that both Memorial and FOM policies lack detail and specifics about possible sanctions or consequences to the individual displaying the disrespectful behaviour. For example, learners reported that they didn’t want to officially report another student because they didn’t know what would happen – they didn’t want that person expelled or barred from classes, they just wanted the misbehaviour to stop. Similarly, a number of staff members remarked that they didn’t want the person who was disrespectful to lose their job, but they wanted some known action to be taken.

In fact, a number of policies reference discipline or the possible consequences of disrespectful behaviour in the policy, by referencing other policies for that information. For example, article A.2.13 in the Respectful Learning Environment Policy for Medical Education states: “Any imposed discipline shall be in accordance with the Memorial University Handbook for non-Bargaining Unit Learners, applicable collective agreements, or Student Code of Conduct”. It would be helpful if the information about possible sanctions to disrespectful behaviour were in an appendix for ease of access.

Other ways to be more transparent about possible sanctions for disrespectful behaviour would be useful.

Long-Term Policy Recommendation

My impression of the FOM policies of learner mistreatment, intimidation, harassment, and professionalism is that a full comprehensive review is needed. I understand that the Professionalism Working Group in the FOM have already identified this as an urgent issue and are ready to begin their work. Therefore, I suggest the following:

10. The Professionalism Working Group, or other appropriate committee, begin a comprehensive review of all policies in the FOM that relate to mistreatment, intimidation, harassment and professionalism with the view to eliminate confusion, redundancy, and inconsistencies and provide greater transparency. All policies need to reflect the same values of respect, fairness, and freedom from mistreatment/harassment in the learning environment. As well, they need to be built on a shared understanding of what constitutes mistreatment, intimidation, harassment and sexual harassment. The policies should also include possible actions, resolutions or sanctions that might be applied to those who are the source of learner mistreatment. These polices need to align with the appropriate Memorial University policies including the Memorial University Sexual Harassment and Sexual Assault Policy and procedures.
As the committee begins work, there are other three issues for consideration:

In my conversations with administrators at Dalhousie University, Western University and the University of British Columbia, they emphasized how important it is to pay attention to language in naming and describing policies and procedures. They described titles like “mistreatment policy” or “policy and processes to address unprofessional behaviour (including harassment and intimidation)”, or “procedure to report incidents of student mistreatment or unprofessional behaviour” as examples that clearly indicate the intent of the policy. All individuals I spoke with thought that the term “respectful learning environment” was vague and open to interpretation.

My point is that the FOM needs to be cognizant of how language may be interpreted, and to pay attention to language used nationally to benchmark certain features of medical training since ‘mistreatment’ is the term used in graduation surveys of the Association of Faculties of Medicine of Canada. Ultimately, the most important thing is that there are well-developed clear policies and procedures that support a respectful learning and working environment for everyone and that these policies are broadly disseminated, understood, and utilized appropriately.

Two ideas from the literature review suggest that:

a) learners/trainees need to be involved in policy development as it relates to mistreatment and harassment. I am uncertain if the Professionalism Working Group has learners on the committee. If not, I would suggest that student members be appointed.

b) policies should support flexibility in training and provide clear exit strategies for trainees being mistreated (e.g., such as leaving learning environments where trainees are being mistreated, or support change of residency program under such circumstances, etc.). I suggest this issue be discussed and considered by the committee.

Structure

Many individuals discussed the problem of the FOM being too siloed, with the result that important information about medical learner mistreatment is not shared and action is delayed, not taken, or not seen to be taken. This has implications for meeting accreditation standards for ensuring the timely investigation of allegations of mistreatment.

Both undergraduate and postgraduate learners want a safe place to be able to report concerns of intimidation and harassment. Both groups of learners suggested the need
for a harassment officer or ombudsperson to be able to work through issues with learners, investigate Red Flags raised about clinical faculty behaviour in evaluations, and be a resource for programs directors and others for the informal resolution of concerns.

It is clear that all reports of mistreatment/harassment from undergraduate and postgraduate learners need to be routed to one responsible person who has the authority and expertise to advise, support and take action to investigate reports of learner mistreatment early. As well, discussions with postgraduate residents, directors of postgraduate residency programs and the literature review emphasized that residency training is very stressful and more support is needed for resident wellness programs.

As part of this unit assessment, I spoke with representatives from the medical schools at Dalhousie University, Western University and the University of British Columbia to assess the structures and processes in place to constructively deal with issues of learner mistreatment/harassment. In my view, the structural model at Western University’s Schulich School of Medicine and Dentistry appears to be a good fit with Memorial’s FOM. This model proposes an Assistant Dean, Learner Equity and Wellness and an Assistant Dean, Faculty Equity and Wellness. Therefore, in order to address issues of learner mistreatment and learner wellness, I suggest that:

**Recommendation**

11. The Office of Student Affairs be reconstituted as the Office of Learner Equity and Wellness. This Office would integrate the non-academic resources of the undergraduate and postgraduate medical education programs together. It would be headed by an Assistant Dean, Learner Equity and Wellness whose primary responsibility would be to address issues of mistreatment including intimidation and harassment and related professionalism concerns of both undergraduate and postgraduate medical learners. Responsibilities would include education initiatives to promote civility and respect and prevent intimidation and harassment in the learning environment, provision of a safe environment for learners to come and discuss issues in confidence, provision of advice, support and direction to those reporting mistreatment, be a resource to others in the FOM with regard to informal resolution of concerns, and timely investigation of reports and complaints except for sexual complaints which would be triaged to Memorial’s Sexual Harassment Office. The person recruited to this position would need to be senior and viewed by their colleagues as highly professional. (As well, a complementary position of Assistant Dean, Faculty Equity and Wellness is recommended and will be discussed in Chapter Five).
The Office of Learner Equity and Wellness would have an Academic Director of Undergraduate Wellness and an Academic Director of Postgraduate Wellness who would provide counseling and other supports to medical education learners. In addition, a Wellness Program Director would develop wellness programs for both undergraduate and postgraduate learners, in collaboration with FOM and Residency Program Wellness committees. Other administrative and support services currently offered by the Office of Student Affairs and the Office of Postgraduate Medical Education would need to be maintained. The Office of Learner Equity and Wellness would be arms length from the Office of Undergraduate Medical Education and the Office of Postgraduate Medical Education.

**Reporting**

All medical education learners in the FOM expressed how important it is to feel safe to report instances of intimidation, bullying, and harassment of all forms. Fear of reprisal and other possible negative consequences were palpable concerns from those who met with me. Thus, addressing concerns about safety and confidentiality are critical to increasing rates of reporting learner mistreatment. Therefore, to address safety and confidentiality concerns of reporting incidents of learner mistreatment and provide a mechanism for timely review and response to concerns, I suggest that:

**Recommendation**

12. Mistreatment concerns be removed from the current QRS reporting system. A new secure on-line reporting system be developed specifically for learner mistreatment such as intimidation, harassment and related professionalism issues. This reporting system would be available to undergraduate medical education learners and postgraduate residents. All reports would be routed to the Office of Learner Equity and Wellness and be reviewed by the Assistant Dean, Learner Equity and Wellness for review and action. At the Office of Learner Equity and Wellness at the Schulich School of Medicine at Western University mistreatment, harassment and professionalism complaints are submitted using a single on-line reporting form. The complaint is sent directly to the Learner Equity and Wellness office for review by the Associate Dean but the complaints are not anonymous. Learners identify themselves when they submit the complaint, however all efforts are made to maintain confidentiality. My understanding is that this allows the Associate Dean to connect with the learner directly by email, to ask for more detail about the issue if necessary, to ask the learner what they would like done about the issue, to provide advice, support or other resources to the learner, and allows for
feedback from the Associate Dean to the learner about what actions were taken to address the complaint.

While it is clear that learners in the FOM want an anonymous on-line reporting system, there are concerns about this as the primary approach to reporting mistreatment concerns. These concerns include: validating submitted complaints; limitations to the type of remedial action that can be initiated to address anonymous complaints; and, due process for the person about whom the complaint is about. On the other hand, anonymous reporting might be a way to track recurrent patterns of mistreatment behaviour by particular individuals over time that leads to some form of action.

Given the complexity of this issue, I am not able to make a recommendation about whether this new on-line reporting system should be anonymous or not. This issue needs a full discussion within the FOM.

**Role Clarification**

A shared understanding by residents, faculty mentors, attending physicians and the employing agency of the specific roles and responsibilities of residents at various stages of training is critical to good working relationships. Because residents are employees of the regional health authority (RHA), clear job descriptions that clarify the employer’s expectations of postgraduate learners is needed. As well, the literature suggests that role clarity is also critical when residents transition from one setting or level of training to another. Residents and administrators noted that role clarity can reduce stress for residents and potentially reduce conflict situations that might trigger disrespectful behaviours.

**Recommendation**

13. The Office of Postgraduate Medical Education, the chairs of Postgraduate Residency Programs and appropriate others partner with Eastern Health to develop clear job or role descriptions for postgraduate learners at each stage of residency training.

14. The Postgraduate Education Committee or appropriate other groups develop formal preparatory training materials that clearly identify roles during periods when postgraduate learners transition from one setting or level of training to another.
Education, Training, and Culture Change about IBH&SH

There is a clear need for systematic, well-designed education and training about the prevention and response to intimidation, bullying, harassment and sexual harassment as well as how to build and foster a culture of civility, respect and resilience. There are many excellent suggestions that are recommended by undergraduate and postgraduate learners, by administrators, and in the literature review on the types of training that need to be seriously considered. Rather than repeat these suggestions, I recommend the following:

**Recommendations**

15. In collaboration with the Professionalism Working Group, the Respectful Environment Working Group (Recommendation 5) and other appropriate committees, the FOM convene one or more working groups to organize education and training specific to the issue of IBH&SH at the undergraduate, postgraduate, and continuing education levels taking into account the suggestions raised by learners and others on pages 36-37 of this chapter and on pages 10-11 of the literature review in Chapter Two. The working group should think broadly and take advantage of expertise at Memorial University including the resources available from the Sexual Harassment Office and the expertise of the Sexual Harassment Advisor. I also suggest consulting with academic faculty members from the Faculty of Business Administration, and other schools and departments who have expertise in areas of organizational culture, civility and incivility in the workplace, social media and issues of bullying and harassment, issues of equity, gender, and other related areas.

Education and training about IBH&SH need to be offered at orientation and repeated and enhanced at regular intervals especially at academic milestones such as early clinical observation experiences, before beginning of clerkship and at various points in residency training. Information and training can be provided in various ways. For example, the University of British Columbia FOM uses standardized patient scenarios of inappropriate, disrespectful behaviour to enhance capacity building in learners as they observe the behaviour, discuss how they felt and reacted to the scenario, and practice filing a complaint about the incident. At Western University, the Associate Dean of Learner Equity and Wellness and the Assistant Dean, Faculty Equity and Wellness deliver talks together on workplace civility to residents and attending physicians together on site.
As well, to broaden perspectives, enhance visibility, and support culture change with respect to the issue of equity and respect in learning and working environments for those in the FOM and the health system, I suggest:

16. The FOM initiate an Equity Speaker Series on the issues of equity, medicine and health care in a changing society. The FOM consider partnering with Eastern Health and other health professional schools at Memorial to bring in dynamic, nationally recognized speakers in this field.

**Communication**

To improve the communication of information to learners related to IBH&SH in the FOM, I suggest the following recommendation.

**Recommendation**

17. The FOM initiate a review of all print and online materials provided to undergraduate and postgraduate learners and FOM websites to ensure that information about IBH&SH, applicable policies and procedures for reporting, available resources and a link to the Sexual Harassment Office website are clearly displayed. As well, one sheet info-graphics should be designed to guide learners in decision making about which FOM or Memorial policy applies to address a concern related to IBH&SH, who to contact, etc. These one-pagers could be prominently displayed in student areas.

**Wellness**

A few concerns were raised by both undergraduate and postgraduate learners about the need for a more welcoming culture with suggestions for more social and family-related activities. To address this concern, I suggest the following recommendation.

**Recommendation**

18. The Office of Student Affairs (or reconstituted office) and Resident Wellness Committees and appropriate others consult with learners about the kinds of social events that would be welcoming for all learners and their families and then organize these types of activities on a more regular basis.
Chapter Three References

1. Committee on Accreditation of Canadian Medical Schools. *CACNS Standards and Elements. Standards for Accreditation of Medical Degree Programs Leading to an the M.D. Degree.* February 2018. CACNS.

2. Committee on Accreditation of Canadian Medical Schools. *Role of Students in CACMS Accreditation Visits and Guide to the Independent Student Analysis. For Medical Education Programs Leading to the M.D. Degree.* March 2018. CACNS.


Chapter Four: Graduate Education and Graduate Students

Office of Research and Graduate Studies

The FOM offers 10 graduate programs at the PhD, Master’s and graduate diploma levels. These programs include the biomedical sciences, community and public health, clinical epidemiology, medical ethics, and health services research. Of the 335 graduate students, 78 are in doctoral programs, 202 in Master’s programs, and 55 in graduate diploma programs. There are also nine post-doctoral fellows.

As is the case with all graduate students at Memorial, graduate students in the FOM are students in the School of Graduate Studies (SGS) and fall under SGS and university-wide policies and procedures, not specific FOM policies. At the same time, graduate students are also students in the FOM. Graduate student concerns are primarily the responsibility of the graduate student officer who is the Assistant Dean, Office of Research and Graduate Studies (RGS), FOM. The Assistant Dean reports to the Associate Dean of RGS whose primary responsibility is related to research.

Graduate students are very important to the research programs of the FOM and to the university as a whole. The RGS office provides service and support to all graduate students related to funding, admissions, academic and thesis support, as well as providing an open door for students to discuss other concerns related to their program. If issues of intimidation, bullying or harassment occur and are brought to the attention of the RGS office, these are handled by the Assistant Dean.

Reporting and Response to Issues of intimidation, Bullying, Harassment and Sexual Harassment (IBH&SH)

Great concern was expressed about the absence of an appropriate reporting system for graduate students for issues related to intimidation, bullying and harassment. Sexual harassment is covered by the pan-university Sexual Harassment and Sexual Assault Policy and procedures. Students may be able to report abuse on faculty teaching evaluations but these are not seen by the RGS office, FOM. While there are three other Memorial policies that might apply to graduate student concerns, the RGS office either did not believe they were applicable to graduate students, or were not familiar with them.

- Respectful Workplace Policy supports a climate of respect in the workplace free from harassment based on prohibited grounds of discrimination and personal harassment but applies only to employees of Memorial University, not students in most cases.
- **Non-Academic Appeals Process** is a procedure that describes how students may deal with inappropriate, unfair or objectionable behaviour conducted by Memorial employees including faculty of the university (excluding sexual harassment). However, the procedure does not appear to have been updated and revised since the 1990’s and is not on Memorial’s policy and procedure website. However, it is on the website of Memorial’s Student Support Center [https://www.mun.ca/student/supports-and-resources/respectful-campus/non_academic_appeals.php](https://www.mun.ca/student/supports-and-resources/respectful-campus/non_academic_appeals.php). Administrators in RGS had no knowledge of this process and procedure.

- **Student Code of Conduct** is a policy that might guide student-on-student harassing behaviour, but was not thought appropriate to address graduate student issues in the learning environment.

In contrast with the three previous policies, the Sexual Harassment and Sexual Assault Policy and procedures was identified by both administrators and graduate students as providing transparent processes for the whole university community – faculty, staff, and students – as well as clear direction to those in positions of responsibility who might be the first contact of a student reporting sexual harassment. Also, information about the policy was easily located on the university website.

Because there is no apparent process to deal with forms of personal harassment (other than sexual), the FOM Assistant Dean, RGS deals with these issues if students come forward. Issues brought to the RGS office most often include harassing or disrespectful behaviour by supervisors, faculty, and technical staff in research labs. It was reported that student to student issues are rarely reported to the RGS office. When issues involve a supervisor or faculty member, the RGS office counsels the student but students are often afraid of retribution. The Assistant Dean RGS tries to handle things informally by meeting with the supervisor or faculty member, if they agree, but this is a difficult scenario. There is no policy to guide the process and RGS has no formal authority in these matters. The issue is even more complicated in the FOM because of the multiple groups of faculty employed (i.e., MUNFA bargaining and various non-bargaining clinical faculty groups).

**Suggestions for Policy Change from Faculty of Medicine Office of Research and Graduate Studies**

A number of suggestions to remedy the current situation were made by the FOM RGS office. First, a number of individuals stated that SGS needs clear policies about reporting disrespectful behaviour towards graduate students that include empowering or
authorizing graduate student officers to address issues “on the ground” to allow for timely informal resolution of concerns. If informal resolutions do not work, an option would be for SGS to have an equity officer to handle these kinds of issues for graduate students. Alternately, Memorial could establish a central equity office, much like the sexual harassment office, to deal with all issues related to other types of harassment and discrimination across the university.

What I heard from Graduate Students

The Medical Graduate Student Society (MGSS) discussed a range of concerns that had been brought to their attention. They also provided the results of a short anonymous survey disseminated to all graduate students on the topic of bullying, intimidation, and harassment.

Of the nine students who answered the survey, six had either experienced bullying or harassment in the learning environment or knew of someone who had. The sources of the disrespectful behaviour were faculty, students and laboratory staff. Most incidents were reported to someone either inside or outside the FOM. The behaviours were described as yelling, being treated poorly, and other bullying and ‘tormenting’ behaviours. Impacts included increased stress, sleep problems, and changing work hours to avoid contact with the source of the bullying.

FOM Graduate students also expressed the following:

- Because of small numbers of students in some programs and labs, students would be afraid to report bullying and harassment if they witnessed it because of confidentiality concerns and possible repercussions to themselves.

- If students have an experience of disrespectful behaviour, who do they go to for advice and reporting? Are there policies that direct them if the source of the bullying and harassment is a student?...a faculty member?...a staff person? They could not find resources on the FOM or the SGS website that provided clear direction except for the Sexual Harassment Office website which was easy to access and provided clear contact information including a hotline.

- Students are fully aware that workplace-type conflicts will arise from time to time given long work hours in some programs, unavoidable stressful situations, and tight working conditions in some labs. However, there are no mechanisms to resolve these types of conflicts. They suggested that a process for conflict resolution for graduate students be developed.
• FOM graduate students can feel separate from the rest of the student body in the FOM. The ‘silo’ nature of programs within the graduate programs along with the separation of medical students from graduate students can add to a feeling of isolation from the larger student community in the FOM. They expressed an interest in more cross-fertilization and connection both within graduate student programs and with medical student groups, such as journal clubs or special interest groups where dialogue about PhD and Master’s level research could be shared for everyone’s learning.

• The role of the School of Graduate Studies (SGS) in their overall university experience is not clear. They believe SGS needs a stronger profile in the FOM.

• All graduate students and faculty in the FOM should be required to participate in a class or module on Professional Conduct so that everyone has the same information and understands the resources and policies concerning bullying, harassment, sexual harassment, etc.

• They expressed a willingness to be part of a committee looking at the issue of bullying and harassment and working on solutions if such a committee was formed.

The following are other comments raised by graduate students:

• One stated that the faculty, staff and other students were universally respectful and that faculty were “very professional, respectful and kind”.

• Two graduate students reported issues with faculty. One reported a professor had been patronising, intimidating and demeaning to members of a class on more than one occasion and that this behaviour was well known within the department. An attempt by the class to discuss the situation at an end of semester de-briefing meeting was ‘shut down’ by another faculty member. One of the two students felt a professor had given an unfair course grade because feedback was withheld on part of a course requirement until the last day of class with no time to redress the situation. The graduate student indicated that the professor would not meet to discuss the issue. This was perceived as disrespectful.

Both students reported the issue to a trusted person in the department but they were not in a position to act on the concerns. The graduate student handbook gave no clear direction on whom to turn to for advice. One student remarked there is no ‘safe place’ to go to voice concerns and is now mistrustful of professors and their stated
expectations of students. In this student’s view, a process of being able to report issues anonymously is required. In addition, a *Respectful Learning Environment Policy for Graduate Students* needs to be developed, identifying clear, fair processes and actions to be taken. Neither student had considered going to the FOM RGS office for advice or support. Both students found other faculty in the department to be fair and respectful.

- One graduate student offered suggestions on how the FOM could be more proactive in meeting the needs of LGBTQ medical and graduate students, as well as patients. This student noted that administrators in Newfoundland and Labrador high schools have embraced the curriculum from EGALE (Equality for Gays and Lesbians Everywhere). Therefore, the next wave of young adults will be more enlightened about these issues. Are Memorial, the FOM, and the health system ready? The student thinks that the culture in the FOM is quite accepting of individuals and appreciates “who you are as a person” but believes there is lack of knowledge and education, as well as defensiveness and discomfort about gender inclusivity, other LGBTQ issues, and sexuality. Proactive measures such as more education and training for medical students and residents including more simulation with standardized patients who are LGBTQ would better prepare trainees for respectful, non-judgmental, knowledgeable clinical encounters. This student also expressed concern that there were no gender inclusive washrooms in the FOM or HSC.

**Perception of Culture and Suggested Solutions of Graduate Students**

Overall, graduate students and RGS administrators I spoke with did not think that the FOM had a culture of bullying, intimidation, harassment or sexual harassment. However, these behaviours do exist in some graduate departments and are difficult to deal with in the perceived absence of clear reporting mechanisms. In the view of graduate students, actions of the FOM appear more reactive than proactive on these issues.

Graduate students need to feel safe to report instances of disrespectful behaviour without fear of repercussion. Both administrators and graduate students identified the need for the development of clear policies and procedures about respectful learning environments free from bullying, intimidation, and harassment as well as the development of processes for conflict resolution. Policies and procedures need to be broadly communicated and easily accessible on-line. Graduate students believe that education about respectful behaviour needs to be mandatory for students, faculty and staff. Supports need to be developed either within the SGS or centrally to guide graduate student officers when dealing with these issues. Graduate student officers need a clear mandate to exercise authority in the informal resolution of concerns.
In addition, the supportive services provided by the RGS office and the role of the Assistant Dean as the graduate student officer needs to be better communicated to all graduate students. The Assistant Dean can be the ‘safe’ person to consult when students have concerns about issues of intimidation and harassment in their particular graduate program. As well, the role of SGS needs to be better communicated to graduate students in the FOM.

As well, efforts could be made to have a more welcoming culture to all students in the FOM so that graduate students feel more included in the larger student body. The FOM could be more proactive on issues relating to LGBTQ issues in light of societal change.

**Discussion and Recommendations**

**Policy**

In order to address the concerns voiced by graduate students in the FOM and by administrators in the FOM Office of Research and Graduate Studies (RGS), I suggest the following actions below. Not all these recommendations are specific to the FOM because graduate students are students in the School of Graduate Studies (SGS) as well as the FOM. My working assumption is that many of the issues expressed by FOM graduate students and those in RGS are not unique to the FOM but may be widespread concerns across the graduate student community at Memorial.

**Recommendation**

19. That SGS convene a working group of graduate officers and graduate students (including FOM members) and others to review the following policies: *Respectful Workplace Policy; Non-Academic Appeals; and, Student Code of Conduct* and assess whether they are appropriate and adequate for the reporting and resolution of issues related to intimidation, bullying and harassment in the various learning and research environments of graduate students.

(*Note that the *University-Wide Sexual Harassment Policy and Procedures* apply to all graduate students).

If these policies are considered appropriate for graduate students, this should be expressly indicated in the policy and should be clearly communicated to all graduate student officers and to all graduate students.

If these policies are not deemed to be appropriate to the learning and research environments of graduate students, the working group develop a clear, transparent policy and procedure for the reporting and resolution of issues related to intimidation,
bullying, and harassment (under the protected grounds of discrimination and personal harassment) for graduate students at Memorial University. The policy needs to explicitly assure freedom from repercussion for reporting and to clearly state that graduate student officers have the authority from SGS to discuss the concern with those involved to allow for timely informal resolution if possible.

**Conflict Resolution**

**Recommendations**

20. The working group develop a Process for Conflict Resolution for Graduate Students. This would facilitate the informal resolution of conflicts, unrelated to harassment and intimidation, that may result from the unique learning and research environments of some graduate students, for example those whose work is primarily in laboratories or other non-classroom venues. As one example, the Graduate Conflict Resolution Centre at the University of Toronto could serve as a resource to the working group.

21. In collaboration with other appropriate units and faculties at the university, SGS develop resources such as education and skills training in mediation and conflict resolution for graduate student officers to better enable them to handle concerns about intimidation, bullying and harassment informally at an early stage.

**Communications**

**Recommendations**

22. The SGS review its communications strategy including its website to enhance the visibility of SGS to graduate students in the FOM (and other faculties and schools). The SGS website could also have a Respectful Learning Environment webpage with links to on-line resources about respectful behaviour, academic bullying, conflict resolution, etc. The webpage could have a link to all Memorial policies and procedures related to the reporting and resolution of intimidation, bullying and harassment of graduate students including the Sexual Harassment Policy and procedures. This page should be linked to the FOM website.

23. The FOM RGS office enhance communication and visibility about the supportive services available to all graduate students including those provided by the Assistant Dean as graduate student officer. Students need to be aware that they can come to RGS to seek advice and support if they are concerned about an issue of intimidation and harassment. This information needs to be prominently displayed in all orientation materials provided to graduate students in all ten programs offered by the FOM.
Education

Recommendations

24. All graduate students and faculty who teach or supervise graduate students in the FOM be required to participate in a class or module on Professional Conduct so that everyone has the same information and understands the resources and policies concerning bullying, harassment, sexual harassment, etc.

25. The FOM review the undergraduate and postgraduate curriculum regarding LGBTQ issues. In order to better prepare trainees for respectful, non-judgmental, knowledgeable clinical encounters, the FOM might consult with recognized leaders in the field of LGBTQ issues such as Susan Rose, the vice president of EGALE, Canada Human Rights Trust who resides in Newfoundland.

Culture

Recommendation

26. To encourage more integration of all graduate students within the broader student body in the FOM, the FOM work with the Medical Graduate Student Society, the Medical Student Society, medical student interest groups, journal clubs and appropriate others to explore ways to share clinical, research and other professional experiences to enhance everyone’s learning and professional development.
Chapter Five: Faculty Members

Academic and Clinical Faculty Appointments

The Faculty of Medicine has a complex arrangement of faculty appointments across multiple jurisdictions including Newfoundland and Labrador, New Brunswick, Prince Edward Island, the Yukon, and Nunavut. As of March 2018, there are approximately 1,339 faculty members in the FOM:

- 88 academic faculty are members of the Memorial University of Newfoundland Faculty Association (MUNFA) and are governed by the MUNFA collective agreement;
- 191 full time clinical faculty (known as GFTs non-bargaining) are practicing physicians holding a joint appointment with Memorial University (non-bargaining) and a regional health authority (RHA), most often Eastern Health;
- 1,064 part time clinical faculty (non-bargaining) are practicing physicians with an appointment to Memorial University and may receive remuneration or a stipend for their teaching or other service to the FOM and or may be non-stipendiary.

There may also be a small number of other appointments such as per course appointments, adjunct appointments, etc.

The Dean’s Office oversees the policies, personnel issues and governance of faculty members. The Office works closely with Discipline Chairs, Associate and Assistant Deans and Vice Dean as well as various committees in the FOM in addition to liaising with Memorial University personnel in the Division of Faculty Relations, the Department of Human Resources, the Office of the Vice President (Academic) and other senior administrative offices. As well, the FOM has affiliation agreements with clinical agencies such as RHAs where clinical faculty members practice and where medical students and residents engage in clinical learning.

Reporting and Response to issues of Intimidation, Bullying, Harassment and Sexual Harassment (IBH&SH)

When any faculty member in the FOM has a concern about IBH&SH, they are able to invoke two Memorial University policies: the Sexual Harassment and Sexual Assault Policy and Procedures and the Respectful Workplace Policy. However, because most clinical faculty members have privileges with an RHA and a few are RHA employees, jurisdictions overlap and policies of both the RHA and Memorial might apply in certain circumstances. As a number of faculty members stated, there is a complex inter-
relationship between the FOM and the RHAs and the management issues related to clinical faculty members are the responsibility of both organizations. Eastern Health does have a policy titled: *Prevention and Resolution of Harassment in the Work Environment*. However, I did not review this policy for this unit assessment report.

In dealing with the issue of harassment of clinical faculty members, there need to be clear pathways for reporting that are well communicated and well understood by all parties involved: the person targeted, the person who is the source of the harassment, and the institutions – the RHAs and Memorial’s FOM.

**Faculty Reports of Intimidation, Bullying, Harassment and Sexual Harassment**

Two full time clinical faculty members discussed their experiences of harassment in the workplace and one faculty and one administrator discussed the impact of anonymous reporting on clinical faculty.

- One specialist physician reported experiencing systematic, prolonged, planned harassment over a 4-year period by a physician colleague close in hierarchy. The harassment began soon after the specialist physician received a promotion and consisted of efforts to undermine the individual’s work, not sharing important information, micro-managing the office they shared, conducting professional meetings without inviting the individual and similar behaviours. The individual reported the harassment to the appropriate leaders in the regional health authority and the FOM. Investigations were conducted and for a time the behaviour improved. However, the harassment started again and the individual felt completely unsupported by the FOM or Memorial. The individual believes that there were (and continue to be) a number of problems with the process of investigations of this kind: the lack of transparency; the reflexive tendency by institutions to defer to privacy and confidentiality policy over the rights of the targeted person; protection of the source of the abuse; conflict of interest issues on all sides; the absence of an independent office or person in the FOM or at Memorial where advice and support could be provided in such circumstances; lack of clarity about policy and possible options the individual could have taken; and, a sense that the individual was “railroaded” into mediation that was not in the individual’s best interest. Because of the stress and impact on this physician’s professional and personal life, the individual eventually resigned from the position and, I believe, now works in a different area of medicine.

- Another specialist physician discussed a situation of unequal workload, pay equity, and issues of harassment, intimidation and gender bias towards mid-
career and older female physicians. The physician reported that she and other female colleagues were the target of sustained harassment and intimidation over a 4-year period that resulted in a toxic work environment. The harassment included mobbing behaviour at meetings, intimidation, ‘ghosting’ behaviour (i.e., not being acknowledged by male colleagues at work or in social situations), verbal abuse, and negative comments made about their work ethic to others. A number of unsuccessful attempts were made to mediate the situation but the female physicians felt that they were “duped” into not making a formal complaint. A ‘Crucial Conversations’ program was started but was not helpful in resolving issues around workload and pay equity. The physician stated that she and her female colleagues were unaware of the appropriate policies, what their rights were, and who to go to for advice. In their view, they were not supported by either the RHA or the FOM. It was only when the female physicians decided to take their case to the Labour Relations Board that the issue was resolved. Since then, the physician reported that the working environment has improved significantly for a variety of reasons.

- One clinical faculty administrator and one administrator reported that clinical faculty are concerned about anonymous reporting. Physicians feel they are being watched and evaluated all the time by clinical clerks and residents, which can feel intimidating. With anonymous complaints, faculty have no recourse or ways to address the issue appropriately. For example one anonymous complaint by a resident was made at the end of a 3-month rotation about an incident that occurred early in the rotation. The faculty member felt the complaint was not truthful or was the result of a misunderstanding but there was no opportunity to address the concern with the resident. It left questions about the true intent of the complaint. Another concern is about the lack of respectful, calm discussion between residents and attending physicians. The faculty member feels that residents sometimes misconstrue comments as “directives” when they were not meant that way. Cultural differences and modes of expression of some faculty may be misunderstood. The faculty member noted that the clinical settings are under stress with high workloads, frequent on-call schedules for attending physicians, and few resources to handle teaching of junior residents.

Impact

As noted in the literature review in Chapter Two of this report, there are few sources of information about practicing physicians as targets of workplace harassment. But the
one U.K. study on the topic reported significant impacts on physicians including demoralization, isolation, depression, home life problems, changing jobs, etc.

Physicians in this unit review describe that being the target of harassment and intimidation had a significant impact on their professional and personal lives including: increased distress, stress and worry; financial consequences; emotional devastation; disruption to family and social life; and, concern about their own health and well-being.

Anonymous complaints cause worry and concern to faculty. It feels insulting and upsetting to be the subject of a complaint that cannot be discussed so all perspectives are given due consideration.

Culture

The three physicians believe the FOM and their work environments display a culture of harassment and intimidation. One physician stated that intimidation was not present every day, but that it was used as a tool to get decisions made and conflicts resolved. The medical culture was described as hierarchical with rigid structures that support gender bias. Another physician felt that a culture of silence and secrecy underpins a culture of harassment. Another physician felt that there was possible “closet” racism and gender discrimination in certain areas.

Solutions Proposed by Faculty about IBH&SH

Reporting and Structure

- Appoint an arms-length, independent harassment officer who can provide objective advice, explain all options, and provide support to faculty members who are targets of personal harassment and intimidation.

- The person appointed as the harassment officer needs to be strong, confident, sure of their own worth and have a thorough understanding of the complex interconnected work arrangements between the FOM and the RHAs.

- Policies need to be transparent and provide clear rules on how negotiation works. Policies need to be applied fairly to everyone.

- Options for possible resolution of concerns and complaints need to be in the control of the individual experiencing the harassment.

- Policies need to explicitly identify the possible consequences of harassing behaviour including; clear warning, demotion, suspension, and dismissal. Public exposure is also suggested as a consequence.
**Education**

- With regard to anonymous complaints, develop guidelines and education about the purpose of feedback to clinical faculty. Clarify what is helpful versus unhelpful feedback.

**Communication**

- Policies need to be widely communicated and accessible to all faculty.

**Culture and Leadership**

- Administrators in the FOM need to believe those who are targets of abuse and take leadership of the issue by taking immediate steps to stop the behaviour early.

- Change the culture to promote collegiality, professional behaviour, honesty, and a willingness to understand the other person. Anonymous complaints that ‘blind side’ people don’t help understanding.

- Promote calm, respectful discussion between residents, clinical clerks, and attending physicians.

**Discussion and Recommendations**

A few suggestions raised in this chapter have been addressed in other recommendations in this report. The concern about clearly stated sanctions in policy was raised in Chapter Three and the need for more professional respectful communication between learners and faculty has been addressed in other sections.

**Structure**

Clinical faculty members can be both the source of intimidation and harassment and the target of these behaviours in the learning and workplace environment. The overlapping jurisdictions between regional health authorities, the FOM, and Memorial make these issues complex. Faculty need a secure place to go for support, advice and direction from someone who is knowledgeable and experienced in the complexities of the work environment of faculty and who is perceived as fair and highly professional. As well, faculty and administrators reported that health care environments can be stressful for everyone, including faculty. In order to provide a source of support for equity, professionalism and wellness issues for faculty, I suggest the following recommendation:
Recommendation

27. A new position titled Assistant Dean, Faculty Equity and Wellness be established to provide a leadership focus on understanding, supporting, improving and advancing equity, professionalism and health needs of faculty.

This will be complementary to the role of the Assistant Dean, Learner Equity and Wellness described in Recommendation 11. Responsibilities of this position will evolve and include: developing strong relationships with the regional health authorities and appropriate offices and departments of Memorial to better support faculty with regard to fair and respectful treatment in the workplace; providing support, information and advice to faculty on issues of equity, professionalism and wellness including guidance on applicable policies; developing remediation plans and providing other supports to faculty who exhibit unprofessional behaviour or have other challenges; developing education and workshops in partnership with the Office of Educational Development in areas of faculty wellness and professionalism; liaise with the Assistant Dean, Learner Equity and Wellness to address issues of mutual concern related to learners and faculty; and a number of other activities. The position would be arms length from the Dean and report to the Vice Dean.

This position is based on a similar position at the Western University Schulich School of Medicine that I referenced earlier in Chapter Three.

Policy

Faculty members described being unaware of the appropriate policies and procedures about respectful workplace free from intimidation and harassment. Because management issues of faculty are the joint responsibility of the regional health authority and the FOM, I suggest:

Recommendations

28. The FOM, Memorial University, and the regional health authorities review their affiliation agreements to clarify jurisdictional issues if at all possible and to communicate the results of this review to all faculty members.

29. The FOM clearly communicate and make accessible on the website all Memorial University policies and procedures regarding IBH&SH that apply to academic faculty members and all policies and procedures of Memorial University and the regional health authorities regarding IBH&SH that apply to clinical faculty members.
Education and a Respectful Culture

Anonymous complaints about faculty are a concern and do not always promote understanding. As well, it was suggested that misunderstandings by learners may occur because of cultural differences or modes of expression different from the dominant culture. To address these two issues, I suggest:

Recommendations

30. The FOM ensure that guidelines and education about the purpose of feedback to clinical faculty by learners and ways learners can provide respectful constructive feedback to faculty be enhanced and implemented at the undergraduate and postgraduate level.

31. The Professionalism Working Group ensure that professionalism education initiatives include discussion about respect and understanding towards cultural differences and modes of communication and how to respectfully ask for clarification about the intent of a message.
Chapter Six: Administrative and other Staff Members

Staff Member Complement in the FOM

The Faculty of Medicine (FOM) employs a variety of administrative and other staff members who are funded either through the operations budget or through grants. At present, there are approximately 344 staff members employed in the FOM. They include:

- 101 grant funded employees (3 permanent; 98 contractual)
  - 91 Non-Bargaining Staff
  - 7 Management and Professional Staff
  - 3 Staff in CUPE Bargaining Unit
- 243 operationally funded employees (181 permanent; 62 contractual)
  - 33 Non-Bargaining Staff
  - 49 Management and Professional Staff
  - 3 Senior Administrative Management Staff
  - 157 Staff in CUPE bargaining unit
  - 1 Maintenance Staff

Staff members work in a variety of settings including larger administrative offices, faculty and learner support units, and smaller more isolated research centres.

The FOM has its own Office of Human Resources (HR) headed by the Manager of the office who reports jointly to the Chief Operating Officer (COO) of the FOM and to the Associate Director of Memorial’s Department of Human Resources. The HR Manager and the COO meet weekly with the Vice Dean, FOM to discuss issues of concern related to staff.

Reporting and Response to Issues of Intimidation, Bullying, Harassment and Sexual Harassment (IBH&SH)

Staff members who experience IBH&SH are able to avail of Memorial’s Respectful Workplace Policy and the Sexual Harassment and Sexual Assault Policy and procedures. Staff can also make a complaint against an undergraduate learner who displays disrespectful or unprofessional behaviour by completing the FOM Professionalism Concern Form. As well, they are able to consult informally with the HR Manager, FOM
for general advice and guidance in the case of personal harassment and with the Sexual Harassment Advisor in the case of sexual harassment. The Department of Human Resources also offers an Alternate Dispute Resolution process to resolve conflicts informally. As well, staff members in the CUPE bargaining unit are able to consult with their union officials on how best to proceed with a concern.

**Staff Experiences with IBH&SH and Reporting**

Seven staff members, three in permanent positions and four in contractual positions, discussed their personal experiences with intimidation, harassment and sexual harassment. Another two individuals, a faculty member and a staff member from the Division of Community Health and Humanities, contacted me to report on a novel approach their division has developed to address issues of disrespect in the workplace. Their experience is reported at the end of this chapter.

**Sexual Harassment Issues**

Two individuals reported episodes of sexual harassment. In one case, the source of the harassment was a clinical faculty member and occurred a number of years ago; in the second case, the source of the behaviour is another staff member and is ongoing. The reported behaviours include the following: unwelcomed gendered comments about appearance; inappropriate comments couched in sexual innuendo on multiple occasions alone and with others present; repeated invasion of personal space; frequent sexist “jokes” around the office; asking the female staff members for hugs; leering looks at female staff; and, making provocative comments about the staff member’s appearance to another colleague in a social setting. These behaviours make staff members feel very uncomfortable to the point of trying to avoid the person if possible and making sure they are never alone with the person.

The staff member, who was harassed by the faculty member, stated that she had not gone to her manager at the time because the underlying message in her unit was that there is a hierarchy of power – faculty over staff – so “don’t rock the boat”. Now, the situation has changed with a new manager who clearly telegraphs the message that staff are professionals deserving of a respectful workplace and there are limits to what is reasonably expected of staff. This staff member reported that she would not hesitate to go to her manager if the same issues occurred today.

While both staff members report knowing about the *Sexual Harassment and Sexual Assault Policy*, they reported they would be reluctant to use any policy for the following reasons: self doubt; afraid of confrontation; concerns about confidentiality; fear of losing control of the process – afraid it would escalate; process is seen as intimidating –
more afraid of the process than of dealing with the harassment; feeling they should be able to handle it; doesn’t know what would happen to the person is reported – no transparency about possible consequences; no faith that anything will change; female staff feel that the ‘bully’ gets protected.

*Other Forms of Intimidation and Harassment*

Five other staff members reported a variety of other intimidating and harassing behaviours by supervisors, academic and clinical faculty, staff members and rarely learners. These behaviours included the following: being yelled at on multiple occasions alone or in front of other staff and witnessing yelling toward other staff; being yelled at during an academic planning meeting; being ordered to return to work after a difficult experience of public humiliation that caused the individual great stress; being sworn at by a supervisor and witnessing swearing toward others on multiple occasions; being unjustly accused of disrespectful behaviour by the person who is the source of the abusive behaviour; undermining staff members’ work; a supervisor repeatedly changing instructions about what work is required; dismissing and not using the work done by staff; inappropriate comments about attire and personal grooming towards a gay individual (verging on sexual harassment); repeated verbal abuse; being subjected to unwanted touching and invasion of personal space; having files ripped out of the person’s hand; told to “make things happen” that were contrary to established policy; told that “the person will be retiring soon, so just put up with it”; witnessing a general lack of respect toward professional staff; being denied time off in lieu of having to work extra hours; ordered to stay late or work additional hours on the weekend thus preventing the individual from attending university classes; “put on the carpet” for following policy; being taken advantage of because the individual is not credited for work done on a research paper/presentation that made the person feel like an “accessory” to the success of faculty and medical students.

There was also an issue related to the discrepancy between advertised job descriptions for research assistants and the actual duties of the job once the person was in the position. For well-educated individuals who expect their job will be about research, it is demoralizing to find that the duties are not as posted and the position is not utilizing their skill set.

Staff members described the impact of their experiences on many aspects of their lives: their relationships with others, lowering self-confidence and self-esteem, physical health and mental health effects, triggering symptoms of post-traumatic stress disorder, all of which impact income earning potential. One young staff member felt that young
people on contracts are particularly vulnerable in a poor economy and therefore will take more abuse because they are afraid of losing their jobs or not being rehired.

Two contractual staff members reported seeking advice about the harassment issue but did not feel they were heard or that nothing could be done. One individual reported feeling that there was more concern expressed for the feelings of the source of the bullying than for the feelings of the person being bullied. Contractual staff fear they can be replaced easily and in smaller more isolated units there may be repercussions to reporting. They do not want to be labelled as trouble makers and fear losing their jobs especially in a tight labour market. Another reason for not formally reporting was that the behaviour was long standing and had been allowed to continue even though faculty members had tried to intervene.

One professional staff member in a permanent position believed that because of the power differential in the FOM, it would be “career suicide” to put in a formal concern/complaint about a faculty member. This individual stated that the Respectful Workplace Policy works well when it is staff to staff but not staff to faculty. Another staff member noted that for many non-unionized professional staff, there is no safe place to go to report concerns of harassment. This individual expressed the need for an arms-length equity officer at Memorial who could provide independent advice, guidance and action.

A contractual staff member noted that when hired for one 6-month contract a few years ago, there was no information provided about the Department of Human Resources and no information about policies. When this individual was subjected to bullying by her supervisor, the individual had nowhere to turn for help. More recently, when hired for another position, the individual was given an appropriate orientation.

**Culture**

Most staff reported that there was not an overall culture of intimidation, harassment, and sexual harassment in the FOM but that the culture allows and tolerates disrespectful and harassing behaviour by some individuals, both faculty and staff. Most agreed that abusive behaviour was limited to a few individuals and that there are “lots of great people”. However, the perception is that the FOM has a culture of conflict avoidance and by failing to address issues, reinforces the abusive behaviours. A number of staff members commented that there is a lack of trust and credibility that issues will be dealt with fairly at all levels of the FOM and Memorial. One staff person felt that women’s ideas are not taken as seriously as ideas suggested by men, but believes this is not limited to the FOM.
Solutions Proposed by Staff Members related to IBH&SH

Policies

- Revise policies to reflect the concept of zero-tolerance for harassment, bullying and intimidation and include clear statements about accountability for behaviour.

- Institute mechanisms that demonstrate to the person reporting abuse that appropriate action was taken to rectify the situation and protect the targeted person. Include strategies that could be used to reconcile the situation amicably.

Reporting

- Appoint a neutral person, like an ombudsperson, who will listen to all concerns and then discuss possible options. This would give a sense of being heard and a greater sense of control. A neutral person, who is arms length from line authority, is critical to eliminate a conflict of interest.

- Institute a standalone independent central Office of Fairness and Equity that reports directly to the President. This would be seen as a safe place to turn for support and advice when other avenues are not available.

- The FOM develop an accountability process and publish a regular accountability report on issues related to a respectful workplace that documents the activities that are happening and how the FOM is doing.

Committees

- Develop a professionalism or respectful workplace committee with broad representation including staff.

Education and Training

- Provide training for managers so that they are confident role models for a respectful workplace and have the skills to deal with disrespectful behaviour early.

- Provide a mid-career staff development program to enhance trust and reduce cynicism.

- Develop mandatory training on a respectful workplace and learning environment for all members of the FOM including faculty, staff and learners.
• Deliver workshops on assertiveness training/coaching on how to handle harassment in the workplace.

• Develop stronger staff orientations for new hires about respectful workplace and continuing training at regular intervals.

Culture

• Involve staff in decision making to make best use of their expertise.

• Recognize the efforts made by staff members when they go the “extra mile” in small everyday gestures of thanks.

• Organize more visible support and celebration of staff members. (The summer Staff Appreciation Day was noted as a great event).

• A clear message about a Respectful Workplace needs to be sent by the Dean.

Communication

• Policies and places to go for help and support related to a respectful workplace need to be widely communicated and accessible.

• Develop and communicate clear expectations of what support units will provide to faculty and learners.

• Communicate the rationale for FOM support unit policies (e.g., scheduling, use of resources, etc.) to faculty to promote better understanding of why not all requests can be accommodated. One individual noted that it is important that faculty separate the person from the policy – “don’t shoot the messenger”. If faculty are not happy with a situation, then take steps to have the policy reviewed and revised.

One Example of Policy-in-Action by the Division of Community Health and Humanities

Five years ago, the Division of Community Health and Humanities (CH&H), FOM decided to address the issue of disrespectful behaviour in their unit. The Division supported a separate retreat for faculty and for staff in order to allow for safe, full discussion of the issues in the workplace. The Division also supported a survey about disrespectful behaviour that was sent to all faculty and staff. The result was the development of a Divisional Respectful Workplace Committee with two co-chairs (one faculty and one staff). The Committee has a mixture of faculty and staff to a maximum of seven people. The Committee developed Terms of Reference and a CH&H Divisional Respectful
Workplace Policy, based on Memorial’s Respectful Workplace Policy. In effect, the Committee translated Memorial’s policy into a working document for their Division by developing: 1) a 20-page document identifying and clarifying specific staff role expectations and examples; 2) a 10-page document that catalogs behaviours and communication that promote civility and respect versus uncivil, disrespectful behaviours and communication as well as definitions and examples of personal harassment, psychological harassment, and bullying; and, 3) a 2-page document clarifying the rights and responsibilities of complainants and respondents.

The two co-chairs of the Divisional Respectful Workplace Committee reported that this approach is working well. Many workplace issues are now addressed informally through collegial discussion without coming to the Committee. Since 2015, when the policies and procedures were implemented, the Committee has dealt with 5 concerns. Of these, staff and faculty have equally been involved in bringing concerns forward and both groups have equally been the subject of a concern. Four of the 5 concerns were resolved informally through the CH&H Divisional Respectful Workplace Policy. One case was thought to be outside the purview of the Committee.

The Committee has a number of roles including policy development, training, monitoring, accountability, and consistency with Memorial’s policies. The Committee reports to the Division as a whole yearly.

In my view, this approach by CH&H is a good example of tailoring high level policy to specific working environments. One Canadian research paper on the issue of intimidation, harassment and discrimination stated: “It appears that the real policy challenge is meaningful and enlightened implementation at the point of learning and care”\(^1\). In my view, this is exactly what CH&H has done for their workplace.

Discussion and Recommendations

Policy

The process used by CH&H to “translate” Memorial’s Respectful Workplace Policy into a working document that fits with their unit culture may be a model that could be adapted for the rest of the FOM to seriously consider. This process could be applied to administrative, service and research units that use the Respectful Workplace Policy to report concerns of intimidation and harassment. It might also be used in learner-faculty and learner-learner situations such as Residency Program Committees and undergraduate learners committees that would use the Respectful Learning Environment Policy in Medical Education to report concerns of intimidation and harassment.
This approach incorporates a number of potential solutions proposed by various groups I spoke with in the FOM, not just administrative units. These include:

- sensitizing everyone to the issues of respect and civility
- normalizing discussion about a respectful environment
- clarifying roles and responsibilities
- setting ground rules about civility and respectful behaviour
- empowering local unit and learner program committees

My one caveat is that the development of the CH&H Respectful Workplace Committee was an organic response to a situation that needed resolution and may not be as successful if imposed on other units. Therefore, I suggest the following recommendation.

**Recommendation**

32. The Respectful Environment Working Group (referenced in Recommendation 5) and other committees invite the two co-chairs of the CH&H Respectful Workplace Committee to share their experience of the development, evolution and function of the committee in their unit. The Working Group could then solicit opinions from other units about whether they might be interested in implementing a similar process in their areas. The FOM could provide support for these initiatives.

**Education**

**Recommendation**

33. The FOM work with appropriate units of Memorial University to provide:

- Leadership training to enhance the ability of managers to be effective role models of civility and respect and have the skills to respond to disrespectful behaviour appropriately.
- Provide opportunities for mid-career staff development programs.
- Develop stronger staff orientations for new hires about respectful workplace initiatives, appropriate policies, where to go for help and support, etc.
- Deliver other training related to IBH&SH including how to recognize it and what to do about it. For example, the Sexual Harassment Office will soon be
delivering Bystander Training that teaches strategies for prevention, and what to do during or after witnessing sexual harassment.

**Communication**

**Recommendations**

34. The FOM and Memorial University clearly communicate and make accessible on the website and on all printed materials all policies and procedures regarding IBH&SH that apply to staff members including where to go for help and support.

35. Managers and others working in FOM support units that provide services to learners and faculty be empowered to develop clear guidelines about the types of services provided and their related policies. This information should be widely distributed so that all users of the service will be informed and more respectful.

**Culture**

Staff members reported feeling under-appreciated at times and felt that efforts to recognize their contributions would improve the culture of respect in the FOM. As well, staff can feel that their expertise is overlooked. Therefore, I suggest the following recommendations.

**Recommendations**

36. The FOM make renewed efforts related to staff appreciation events, both big and small, to foster a culture of respect and to publicize these initiatives so that everyone in the FOM are aware of these initiatives.

37. The FOM acknowledge the expertise of staff by including them on decision making committees or working groups.

**A General Concern**

In my conversations with staff members, I became concerned about younger, contractual staff members who are located in small units that may have minimal administrative oversight. If there are issues about intimidation, harassment or other types of abuse in these units, their options about reporting seem limited for the reasons they described earlier in this chapter. I do not know enough about the administrative structure of these units, so I cannot provide a recommendation. However, I would urge the FOM to review how these smaller units are managed and if there needs to be more monitoring or more supports in place especially for contractual staff.
Chapter Six References

Chapter Seven: Overall Conclusion and Final Recommendations

Taken as a whole, my overall impression of the culture of Memorial’s Faculty of Medicine (FOM) is that it is generally a respectful environment and a good place to learn and work. However, while there is not a pervasive culture of intimidation, harassment and sexual harassment, there is a culture that tolerates disrespectful and harassing behaviour by some individuals in some areas. The perception is that the FOM and Memorial University do not always address these issues in a transparent, timely manner allowing the disrespectful behaviours to continue.

There is also an undercurrent of gender-related issues in some of the examples reported by both women and men who came forward to speak with me or submitted written comments. Some female students, faculty and staff do not feel they are treated with respect when subjected to gendered comments, unwelcomed behaviours, and perceived gender bias in their learning and work environments. Generally speaking, women reported about their own experiences while men reported witnessing or being aware of these issues from their fellow students or colleagues. Many of the messages about female medical students and female physicians may be cloaked in the “hidden curriculum” and clearly do not represent the official values and mores of the FOM or Memorial University.

Given the material presented in the review of literature in Chapter Two of this report, these conclusions are not that surprising. The persistence of issues of intimidation and harassment in medical schools across the country and internationally is well recognized and is why accreditation standards both for undergraduate medical education and residency training in Canada are increasingly more stringent. I am very optimistic that the current administration of Memorial’s FOM will initiate new strategies to enhance a respectful learning and working environment and will work diligently to establish more robust approaches to constructively deal with issues of disrespectful and unprofessional behaviour.

Final Recommendations

I have two final recommendations. The first concerns the Sexual Harassment Office and the second the establishment of a position for an Equity Officer or a Central Office of Equity and Human Rights.

In this unit assessment, it became very clear that the Sexual Harassment Office (SHO) is a very hard working unit and has accomplished a great deal in developing a clear comprehensive set of policies and procedures, excellent educational materials, support
and counseling services, along with its many other initiatives. The SHO services the needs of both the St. John’s campus and Grenfell campus. Given the needs I saw at the FOM for the expertise of the Sexual Harassment Advisor, I expect the SHO will be soon overwhelmed by the requests for participation on committees, delivering educational workshops and sessions, and so forth to learners, faculty and staff in the FOM. In light of the rising expectations, I suggest:

Recommendation

38. Memorial University consider increasing the staff complement of the Sexual Harassment Office to support the expected increasing demand for services by students, faculty and staff at Memorial University.

In addition, it also became clear in this unit assessment that while sexual harassment complaints are well handled through a stand alone, university-wide office and position, there is no equivalent office or position of the same stature to deal with equity issues such as personal harassment and discrimination. In a quick review of the other Canadian universities with Faculties of Medicine, I believe almost all had an equity office. Discussions with faculty who deal with graduate students, clinical faculty who struggled with concerns of sustained workplace personal harassment, and professional and contractual staff who experienced workplace intimidation and harassment, all called for the establishment of an Equity Officer or a central Office of Equity that is arms length from line authority. This officer/office could provide independent, confidential advice, direction and support to faculty, staff and students and be a resource to administration in the handling of matters related to personal harassment and discrimination. Given the changes in society, this may be the time to consider this position at Memorial. Therefore, I suggest the following recommendation.

Recommendation

39. Memorial University establish a position for an independent Equity Officer or establish an independent central Office of Equity.
Appendix A
DATE: Nov. 23, 2017

TO: Learners, Staff, and Faculty Members in the Faculty of Medicine

FROM: Dean Steele, Faculty of Medicine

SUBJECT: Faculty of Medicine Unit Assessment

It has come to my attention that there have been several concerns raised about the Faculty of Medicine’s learning environment that are extremely troubling to me as the Dean. These concerns have included allegations of bullying, intimidation, harassment and sexual harassment. In order to learn and work effectively and to reach our greatest potential, all members of the Faculty of Medicine community, our learners, our staff and our faculty collectively have an obligation to treat everyone with respect in order for the Faculty of Medicine to be a safe and nurturing learning environment.

As a result of the issues that were brought to my attention, I contacted the Sexual Harassment Advisor, Ms. Rhonda Shortall, indicating the incidents and concerns raised may be of a sexual nature and may constitute sexual harassment under the Sexual Harassment and Sexual Assault policy. As per section 2.9 of the Sexual Harassment and Sexual Assault policy, I asked Ms. Rhonda Shortall to seek the President’s authorization for a Unit Assessment. Ms. Rhonda Shortall agreed that the circumstances warranted enactment of section 2.9 and, as such, she requested the President order a Unit Assessment, which President Kachanoski has indeed authorized.

A Unit Assessment is defined in the Sexual Harassment and Sexual Assault policy as:
“An independent third-party review of the work, study or research environment that seeks to gather information that relates to issues of sexual harassment in the unit and to identify causes and effects and to make recommendations to the unit.”

The Unit Assessment will focus on:
- The application and alignment of the Faculty of Medicine’s policies so they are in alignment with Memorial University’s Sexual Harassment and Sexual Assault policy
- The culture and the learning environment as it pertains to the reporting and response to incidents of sexual harassment and sexual assault.

Further information about the details of the Unit Assessment will be provided after a decision is made with respect to the external investigator and the terms of reference of the Unit Assessment.

As the Dean of the Faculty of Medicine, I am committed to a learning environment free of bullying, intimidation, harassment, sexual harassment and sexual assault. I will keep the Faculty of Medicine aware of the next steps as they are available. Such a Unit Assessment will enable the Faculty of Medicine to improve our culture so that we can all learn and work in an environment that is safe and respectful.

Margaret

PROFESSOR MARGARET STEELE / DEAN OF MEDICINE
MD, FRCP, M.ED, DFCPA, CCPE

Faculty of Medicine, Office of the Dean
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Appendix B
TERMS OF REFERENCE

UNIT ASSESSMENT – FACULTY OF MEDICINE

In correspondence to Dr. Margaret Steele, Dean of Medicine, dated November 17, 2017, Dr. Gary Kachanoski, President and Vice-Chancellor of Memorial University of Newfoundland, authorized a Unit Assessment in the Faculty of Medicine to ensure that Memorial’s learners, faculty and staff have a safe and respectful learning environment that is free from bullying, intimidation, harassment and sexual harassment.

The Reviewer shall gather information that relates to issues of bullying, intimidation, harassment, sexual harassment and a safe and respectful learning environment in the Faculty of Medicine and make recommendations for the Unit, having particular regard to:

- The application and alignment of the internal policies and procedures within the Faculty of Medicine with Memorial’s Sexual Harassment and Sexual Assault Policy/Procedures and Respectful Workplace Policy/Procedures.

- The assessment of the culture and learning environment as it relates to the reporting and response to incidents of bullying, intimidation, harassment and sexual harassment.

In the course of the assessment, the Reviewer shall:

- solicit, receive and review feedback from students, faculty and staff within the Unit, and such other persons as the Reviewer considers appropriate, which could be written or verbal, at the Reviewer’s discretion;

- interview any persons whom she or he believes have or ought to have information relevant to the investigation, and who consents to be interviewed.

The Reviewer shall be provided with such information and materials as she or he believes are relevant to complete the assessment, and should contact the Faculty of Medicine’s Manager of Academic Affairs, to arrange for such information and materials to be provided.

The Report will be delivered to the President by no later than April 15, 2018, or any extended date that may be granted by the President, following consideration of a request from the Reviewer.

The Report will be publicly disclosed, subject to protection of personal information about individuals.

Allegations against individual members of the University community shall not be the focus of this Unit Assessment.
Appendix C

Offices Contacted for this Unit Assessment

**Faculty of Medicine, Memorial University**

Medical Education Scholarship Center
Medical Graduate Student Society
Office of the Dean
Office of Human Resources
Office of the Policy Analyst
Office of Postgraduate Medical Education
Office of Professional Development
Office of Research and Graduate Studies
Office of Student Affairs
Office of Undergraduate Medical Education

**Other Memorial University**

Faculty of Business Administration
School of Graduate Studies
Office of the Senior Policy Analyst
Office of the Deputy Provost (Students)
Sexual Harassment Office

**Other**

Admissions and Student Affairs, Faculty of Medicine, Dalhousie University, Halifax, NS
Clinical Partnerships and Professionalism Office, Faculty of Medicine, University of British Columbia, Vancouver, BC
Legal Education and Human Rights Consultant, St. John’s, NL
Learner Equity and Wellness Office, Schulich School of Medicine and Dentistry, Western University, London, Ont.
Professional Association of Residents of Newfoundland and Labrador (PARNL)
Appendix D

Policy-related Documents Reviewed

**Union Contracts and Guides**

- MUNFA (Faculty Association) Collective Agreement
- LUMUN (Lecturers’ Union) Collective Agreements (Per Course Instructors and Postdoctoral Fellows)
- TAUMUN (Teaching Assistants’ Union) Collective Agreement
- NAPE (Newfoundland and Labrador Association of Public and Private Employees) Collective Agreements (Campus Enforcement and Patrol, Custodial Personnel, and Maintenance Personnel)
- CUPE (Canadian Union of Public Employees) Guide for Non-Bargaining, Management and Professional, Senior Administrative Management Employees

**Memorial University of Newfoundland Policies and Procedures**

- Conflict of Interest Policy
- Student Code of Conduct (Policy and Procedure)
- Respectful Workplace Policy
- Procedure for Early Resolution of Respectful Workplace Concerns
- Procedure for Resolution of a Formal Respectful Workplace Complaint
- Sexual Harassment and Sexual Assault Policy
- University Wide Procedures for Sexual Harassment and Sexual Assault Concerns and Complaints

**Faculty of Medicine Policies and Procedures**

- Respectful Learning Environment for Medical Education (Policy and Procedure)
- Statement of Professional Attributes
- Process for Addressing Breaches of Professionalism by Undergraduate Medical Students
- Professionalism Concern Form
- PGME Evaluation, Promotion, Dismal, and Appeal Policy

**Other Documents**

- Undergraduate and Postgraduate Learner Course, Faculty and Rotation Evaluation Forms
- All literature referenced in this Report