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TWELVE TIPS

Twelve tips to foster healthcare student recognition and reporting of unprofessional behaviour or concerns

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ABSTRACT

Medical trainees and students are required to report concerns where they identify concerning practice or behaviours. While leadership attributes and skills are increasingly expected curricular outcomes, students still struggle to report concerns due to a variety of factors. Changing societal awareness and expectations continue to shine light on poor professionalism and unethical behaviours whose reach extends to medical training and education and that need to be systematically reported and addressed. To prepare graduates for these challenges in professional practice and for exercising skills of reporting concerns, education and training environments must ensure that speaking up is ingrained in the organisational ethos. Supported by evidence from the literature and our experience of revising and enhancing approaches, this paper outlines tips for developing and embedding an infrastructure that facilitates robust concerns reporting and management. Further, we consider mechanisms that support students to develop tendencies and skills for reporting concerns.

KEYWORDS

Professionalism; leadership; student support; undergraduate; ethics/attitudes

Introduction

The expectation for healthcare staff and students to systematically recognise, report and challenge concerning practices or behaviours in professional settings is well established and is required by the UK medical regulator (General Medical Council 2013). Medical students' reluctance and uncertainty regarding reporting concerns has been identified repeatedly (Elnicki et al. 2002; Goldie et al. 2003; Johnson et al. 2018; Kakkar and Lynch 2019; Druce et al. 2021). Myriad factors influence this behaviour; lack of recognition or uncertainty about the significance of a potential concern (Johnson et al. 2018; Druce et al. 2021) and lack of knowledge or 'ownership' of the responsibility to report (Rennie and Crosby 2002; Druce et al. 2021). Concerns regarding the adverse interpersonal impact of reporting a peer or colleague are also well described barriers to reporting concerns (Kohn et al. 2017; Kakkar and Lynch 2019; Druce et al. 2021), as is fear of adverse impact on academic progression (Rennie and Crosby 2002; Goldie et al. 2003; Bell et al. 2021; Druce et al. 2021). These apprehensions may be particularly pronounced in contexts where the power differential between supervisors and junior trainees or students may be considerable (Minkina 2019). Students too will be exposed to the 'hidden curriculum' (Cribb and Bignold 1999) and may be conflicted regarding formal expectations for professionalism and, by contrast, what may be accepted as the professional culture and norms within clinical professions (Kohn et al. 2017). Targeted educational interventions to address and support this professional requirement have demonstrated varying degrees of effectiveness (Goldie et al. 2003; Parmelli et al. 2012; Donnelly 2015), however clear examples of where medical students speaking up have impacted positively on patient safety are reported (Seiden et al. 2006).

The impact of poor professionalism and the difficulties that medical students have in reporting patient safety concerns have been explored extensively (Dyrbye et al. 2010; Rees and Monrouxe 2011). Recent defining societal events, including the #*Metoo* and the *Black Lives Matter* movements, have amplified messages regarding 'speaking up', addressing injustice, mistreatment, and poor professional behaviours. It is increasingly evident that these issues pervade medical education and training, and that they disproportionally affect women, non-white students and LGBTQIA + students (Hill et al. 2020). In a systematic review of harassment and discrimination in medical training, nearly 60% of trainees had experienced harassment during training and one third experienced sexual harassment (Fnais et al. 2014). In a recent survey of students at one German medical school, almost 59% of students had experienced sexual harassment during their education (Schoenefeld et al. 2021). Despite its frequency, mistreatment regularly goes unreported (Phillips et al. 2019; Bell et al. 2021). Black, Asian and minority ethnic students experience incidents of isolation, microaggressions and overt racism (Cardiff University 2017; Morrison et al. 2019), and students do not always feel secure or know how to report their concerns. Such occurrences are implicated in impeding academic progression (Woolf et al. 2008).

In ensuring graduates are ready to meet the expectations of healthcare professions, students must develop skills and practices of speaking up and driving action in the face of impropriety, mistreatment, and unethical behaviour.

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Universities and healthcare organisations have a duty to provide safe, fair environments for training and professional practice, where speaking up is ingrained in the organisational ethos and culture. This paper outlines key considerations and guidance for developing robust concerns reporting procedures and an organisational culture that embeds skills for reporting concerns amongst healthcare graduates.

Tip 1

Consider the iceberg effect in relation to reporting concerns

Infrequent reporting of concerns by students should not necessarily be accepted as assurance that concerning practices, behaviours or incidents are not being experienced by and impacting on students. Recognising hidden or unreported occurrences is necessary to accurately assess the situation – the so-called 'iceberg effect'. Students are often aware of the highly transient nature of individual clinical placements. They may regularly experience limited feelings of integration and belonging. This, coupled with the knowledge that they will soon be moving on to another clinical location, may also deter students from questioning accepted practice and norms (Elnicki et al. 2002; Rees and Monrouxe 2011; Bell et al. 2021).

From a faculty perspective, introducing or enhancing a reporting concerns process is likely to result in increased levels of reporting. It must be acknowledged that investigating and managing increasing numbers of concerns requires resources including time. However, failure to effectively address concerns may deter future reporting and promote students' ambivalence and tolerance of unprofessional practice or unethical behaviours (Johnson et al. 2018; Kakkar and Lynch 2019; Bell et al. 2021).

Indicators to faculty that concerns are going unreported may include hearing of concerns incidentally or anecdotally, in findings from internal or external surveys, or after an incident has passed or has been addressed elsewhere. While swift and contained local action may be appropriate in some circumstances, this does not support learning from a programme perspective and limited actions may deprive opportunities for wider student or organisational learning, thus the risk of recurrence remains unaddressed.

Tip 2

Create a culture that empowers students to report concerns

Students should be educated from induction regarding their professional duty to report concerns, with reference to professional requirements and guidance. Resources produced by professional organisations can be used to support learning (General Medical Council 2015, 2020). Evidence suggests that in deciding to report a concern students are influenced by their ongoing experiences and interactions within educational and clinical institutions, thus the decision to report is not taken in isolation. Students undergo processes of 'situating' where they reach understanding of their own role through developing awareness of the formal and informal values of the organisation, informed by feedback. This process regulates their level of trust and safety in that organisation (Bell et al. 2021). By demonstrating institutional commitment to investigating, addressing, and learning from concerns, this signals to students and staff not only the importance of speaking up, but also the expectation that concerns will arise. This should begin to normalise the process, establish students' trust, and allay apprehensions about repercussions to them for speaking up.

Cultural dissonance can occur for students moving from 'classroom' settings with clear professional boundaries, to clinical settings where the same boundaries may not be observed. 'Hidden curriculum' learning and accepted professional norms may be embraced by students seeking rapid socialisation within clinical teams. Consistent professional standards should extend across all settings where students may be placed during training.

Widening of access to medical education has shifted the profile of student populations, with increasing numbers of students from ethnic minority backgrounds and students with disabilities being admitted to medical programmes (Medical Schools Council Selection Alliance 2019). It is important to consider and reach out to particular student groups who might be systematically disadvantaged and less empowered to speak up as they may be more likely to be directly affected by incidents and microaggressions (Morrison et al. 2019).

Tip 3

Establish shared objectives and information-sharing with stakeholders

Due to the complex delivery structure of medical education, students rotate through numerous locations and organisations during their education and encounter a variety of education and clinical staff, factors that are known to impact on the consistent reporting of concerns (Elnicki et al. 2002; Druce et al. 2021). Concerns will arise in both the university-based medical school and clinical learning environments, where patient safety is more likely to be directly compromised. Reporting concerns needs to be recognised and treated as a shared responsibility by all medical education stakeholders. Healthcare organisations are required to have their own reporting concerns processes and students should be made aware of and inducted to these. Students will usually have the option – and may feel more comfortable - to report a concern using medical school-based procedures. A cohesive and collaborative approach should be taken by all education partners to reporting, information-sharing and learning from a programme perspective. Otherwise, patterns of repeated lower-level concerns may remain undetected and opportunities for systematically addressing student or faculty development needs may be missed. This collaborative approach presents reporting concerns as a collective duty of various stakeholders rather than an adversarial process.

Tip 4

Define what might be considered a concern, provide examples and reasons

Risks and concerns may fall into a range of categories; patient safety risks may be obvious and reporting infrastructure is well-established here (General Medical Council 2015). However, other ethical or professionalism concerns with no immediate adverse patient consequences, such as probity or attitude, may appear more ambiguous or contextually acceptable within the professional culture (Kohn et al. 2017; Bell et al. 2021; Druce et al. 2021). Specific complexities and barriers to reporting some of these less obvious concerns exist. Students may experience uncertainty in relation to moderate concerns (Gill et al. 2015), so drawing from a range of appropriately anonymised and disidentified sample reported concerns provides authentic examples to share with students in an educative capacity (Nicholson and Tait 2002; Bell et al. 2021). Social change brings new concerns to the fore, so sample case studies should be regularly reviewed and updated, ensuring that guidance remains current and fit for purpose.

Institutional values and policies regarding expected behaviours should be highlighted, with examples of concerns situated in such policies and procedures, thereby demonstrating them in action. Sample protocols for investigation and remediation can also be shared, to assure students regarding organisational transparency and commitment to addressing concerns. The opportunity to discuss concerns with a mentor (staff or student) or participation in group reflection sessions may help students define whether an incident is concerning and correct any misconceptions (Duffy et al. 2012). Students should also be made aware of possible outcomes and action that may be taken and that in cases of severe and/or repeated transgressions or concerns being reported about an individual, including students or faculty, consequences may be severe, including exclusion or dismal from the institution.

Tip 5

Equip students with skills to speak up and report concerns

Well-recognised barriers to students reporting concerns are lack of confidence in their judgement and role uncertainty as a student; in clinical environments they may view themselves as a junior, peripheral team member, thus lacking credibility (Rees and Monrouxe 2011; Bell et al. 2021).

In response to a number of drivers, e.g. increasing recognition of the prevalence and harm associated with microaggressions, sexism and mistreatment, many universities now provide Active Bystander training (Banyard et al. 2007). The objectives of this intervention include developing the ability to identify and interpret unacceptable behaviour, understand reasons why these behaviours may go unchallenged or unreported, and developing students ability and confidence to effectively intervene in concerning scenarios (University of Warwick 2022). Such training may support students in recognising concerns and may provide tools to act where concerns arise, be that by actively intervening or directing concerns to leadership. Institutional promotion of such training communicates the importance of upholding departmental and institutional values.

Tip 6

Establish robust and accessible channels and mechanisms for reporting

Information regarding reporting concerns and the mechanisms available to students should be visible to students, from the point of induction. Information should be provided in student-facing platforms including in student handbooks, on virtual learning environments, mobile apps and webpages, and also displayed at clinical education spaces (Druce et al. 2021). Students should be provided with details of staff members or other reporting champions, including at placement locations, with whom they can discuss concerns in person or online. Where students are aware of hierarchies and power differentials in clinical environments, they may feel safer reporting concerns to the medical school. Noting this, and other barriers to students' reporting, the option to report concerns directly back to and through the medical school's own procedures should be available to students when on placement.

Reporting processes should be underpinned by appropriate administrative infrastructure and supported by trained staff. Lines of responsibility for investigation and correspondence in relation to concerns should be defined and disseminated. Clear lines of responsibility should exist for monitoring incoming reports, investigation and for following up with student reporters to ensure that they can access any support that they may need (see Tip 9).

Tip 7

Consider the case for anonymity

Numerous deterrents prevent clinicians at all levels from reporting concerns (Rich et al. 2019); these are even more impactful in the case of students (Rennie and Crosby 2002; Goldie et al. 2003). Students should be assured that their privacy will be protected throughout reporting and investigations, through use of confidential reporting. Confidential, versus anonymous, approaches have been recommended in safety management and quality improvement in other, non-medical, sectors (Nicholson and Tait 2002). Confidential reporting ensures that the fullness of relevant information can be accessed from individuals making reports, and that they can be offered any support required (Barach and Small 2000; Druce et al. 2021); and receive feedback on actions taken. This also may deter exceptional vexatious or false reporting (Nicholson and Tait 2002), a behaviour which itself falls short of the professionalism expected of medical students. These considerations should be conveyed to students in all supporting information, on reporting portals and forms. Nonetheless, students may still fear being recognised as the source of a report and will, in some circumstances, prefer to remain anonymous (Johnson et al. 2018). Organisations generally provide this option to staff to protect against adverse consequences to them arising from reporting e.g. reactionary victimisation or bullying,

and to optimise rates of reporting (Barach and Small 2000). So while confidential reporting should be considered and encouraged where at all possible, considerations for anonymity should extend to students during initial experiences of reporting concerns while students become accustomed to 'speaking up'. Despite some limitations, anonymous reporting does enable scoping the size of the 'iceberg' and recognition of patterns which can direct faculty and student development.

Tip 8

Explore the role of reporting champions

In addition to provision of information regarding reporting concerns and reporting procedures, access to a neutral mentor or Ombudsman has been suggested as a useful support mechanism for students (Kohn et al. 2017; Druce et al. 2021). These are analogous to the roles of 'Freedom to Speak up Guardians' in NHS trusts (National Guardian's Office 2020) or Patients' Ombudsman, responsible for safeguarding the rights of patients who complain about a healthcare provider (Fallberg and MacKenney 2003). Providing access to an individual who is impartial and independent of the education programme or student progression decisions may provide reassurance and encourage students to report concerns, particularly in circumstances of uncertainty or discomfort. Peer mentoring or student champions have been suggested a means to address these objectives, thus enabling students to access near-peer support. This may remove some of the concerns regarding repercussions for reporting and fear of not being taken seriously, and provide a means to safely explore and discuss their concern. Where student champion roles are developed, these students should be provided with appropriate training to effectively support their peers, as well as to recognise their remit and limitations of their role. Champions must recognise where their peers should be directed to specialised student support e.g. trained personal tutors. Champions should also recognise and uphold their own role in reporting concerns, particularly where this may be in conflict with loyalty or duty of care to junior peers. Specifically, they need to be aware of exceptional circumstances where it may be necessary to breach confidence of a peer.

Tip 9

Provide support for students reporting concerns

The decision-making process to report a concern can provoke apprehension, anxiety, and distress. As discussed earlier, students may fear rejection or alienation by peers or those they previously identified as role models (Rennie and Crosby 2002; Rees and Monrouxe 2011; Kohn et al. 2017). Fear regarding detriment to academic progress is also well described (Rees and Monrouxe 2011; The Lancet 2011; Kohn et al. 2017; Kakkar and Lynch 2019; Druce et al. 2021). The student(s) involved may have witnessed or been directly affected by unprofessional behaviours or mistreatment. The body of literature regarding bullying and harassment of medical students is considerable (Rees and Monrouxe 2011; Fnais et al. 2014). Students should be reminded in all information pertaining to reporting concerns and throughout the process of the supports available to them. These may include access to an experienced, trained personal tutor and opportunities to meet with programme staff or clinical staff to discuss their concern and be briefed regarding investigative processes or actions. As in Tip 8, student champions should be trained to encourage those reporting concerns to consider their need for support, and champions should be able to signpost peers to appropriate supports. While supports here should be tailored to the individual, the interplay between the individual and the organisational culture should not be overlooked (Rees and Monrouxe 2011; Talash et al. 2022). Providing targeted support, in the absence of a supportive organisational culture, is likely to be inadequate and may even be counterproductive by causing students further moral distress (Talash et al. 2022).

Tip 10

Use reports to promote a learning culture

Any concerns identified should be used to promote 'organisational learning'; learning supported by the use of valid knowledge that allows the organisation to improve (General Medical Council 2015; Leistikow et al. 2017). This may include addressing a gap in the curriculum (or acknowledging impacts of the hidden curriculum) or addressing faculty development needs. Examples of concerns can be explored in professional development and ethics teaching, and opportunities for facilitated small group discussion and supported reflection can provide rich, authentic learning opportunities. Examples of safety, ethical or professionalism dilemmas can also be integrated effectively into case-based learning. Interventions exploring organisational power dynamics have also been suggested as ways to increase student trust and support professional development (Angoff et al. 2016). Human factors training may address practices that compromise patient safety in clinical organisations. Emergent developmental needs could include equality, diversity and inclusion training or racial awareness training for staff and students to understand the impact of and reduce the incidence of microaggressions and other non-inclusive practices.

Tip 11

Close the loop in relation to concerns reported and outcomes

As with any procedure that relies upon student engagement for effective functioning, it is imperative to 'close the loop' with stakeholders, including with students who have reported concerns and with individuals responsible for implementing actions (Peters et al. 2019; Bell et al. 2021; Druce et al. 2021). In addition to direct communication with those reporting concerns, it may be appropriate to share high level outcomes or findings more broadly with student groups and education stakeholders, for example if policy change has resulted. Reporting of an individual concern may precipitate further, similar reports, allowing a more accurate estimation of the extent of an issue (Nicholson and Tait 2002). Consideration should be given

to confidentiality and disidentifying recognisable details in any wider communications to students or staff.

These individualised and, where appropriate, collective responses at cohort level convey to students their impressions or concerns were well-founded and that their views are valued and are given due consideration and attention. Where students can recognise themselves as having a role and responsibility as agents of change in improving organisational culture and safety, this may serve an important formative and professional identity development function (Lizzio and Wilson 2009). Failure to share decisions, outcomes and rationale (particularly where limited or no action has been taken), will not only cause disengagement with reporting concerns but will also likely lead to confusion and ambiguity when similar situations are encountered later in professional practice and where greater potential for patient harm may exist (Bell et al. 2021).

Tip 12

Track trends, changes and patterns over time

Reporting and documentation processes and infrastructures should enable tracking of the journey of individual concerns, investigations, and dissemination of outcomes (Nicholson and Tait 2002). Actions should be implemented, and outcomes disseminated proportionately with stakeholders, including clinical education partners.

Further, monitoring and recording should facilitate tracking over time to allow identification of where patterns may be emerging and where educational or faculty development needs may be arising (see Tip 8). Periodic summary overviews should be disseminated and tabled at curriculum quality management groups. Findings should inform and shape future practice and policy and be shared with students.

Conclusions

Universities and healthcare organisations have a duty to provide safe, fair environments for training and professional practice, where speaking up is established and valued in the organisational ethos and culture. Medical students need to be supported in developing skills and tendencies towards reporting concerns. Considerable evidence exists in relation to barriers to students reporting concerns, and this evidence provides a suitable starting point for addressing and removing obstacles. Among the steps that can be taken are provision of comprehensive, accessible information, demonstration of institutional commitment to investigating and learning from concerns, and transparency in closing loops with students and other stakeholders. Peer or near-peer mentors or champions can normalise the process of exploring and reporting concerns for students.

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KO and HAN were involved in developing and redesigning the reporting concerns process and review concerns reported. KO supports students reporting concerns.

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