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Article abstract

Introduction: Up to 98% of practicing family physicians, and over 75% of resident physicians in Canada experience abusive incidents. Despite the negative consequences of abusive incidents, few residents report these events to their supervisors or institution. We sought to estimate the prevalence of abusive incidents experienced or witnessed by Saskatchewan family medicine residents (FMRs) and identify their responses to these events.

Methods: Anonymous survey invitations were emailed to all 110 Saskatchewan FMRs in Saskatchewan in November and December 2020. Demographic characteristics, frequency of witnessed and experienced abusive incidents, sources of incidents and residents' responses were collected. Incidents were classified as minor, major, severe, or as racial discrimination based on a previously published classification system.

Results: The response rate was 34.5% (38/110). Ninety-two percent (35/38) of residents witnessed a minor incident and 91.7% (32/36) of residents experienced a minor incident. Seventy-one percent (27/38) of residents witnessed racial discrimination while 19.4% (7/36) of residents experienced racial discrimination. Patients were the most common source of abusive incidents. Twenty-nine percent of residents reported abusive incidents to their supervisors. Most residents were aware of institutional reporting policies.

Conclusions: Most Saskatchewan FMRs experienced or witnessed abusive incidents, but few were reported. This study provided the opportunity to reassess policies on abusive incidents, which should consider sources of abuse, confidence in reporting, and education.

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Brief Reports

Intimidation or harassment among family medicine residents in Saskatchewan: a cross-sectional survey

Intimidation ou harcèlement visant les résidents en médecine familiale en Saskatchewan : une enquête transversale

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Abstract

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Résumé

Introduction : Jusqu'à 98 % des médecins de famille en exercice et plus de 75 % des médecins résidents au Canada sont victimes d'incidents de violence. Malgré le préjudice subi, peu de résidents signalent ces incidents à leurs superviseurs ou à l'établissement. Nous avons tenté d'estimer la prévalence des incidents de violence dont ont été victimes ou témoins les résidents en médecine familiale (RMF) en Saskatchewan et de connaître leurs réactions face à ces situations.

Méthodes : Des invitations à participer à un sondage anonyme ont été envoyées par courriel aux 110 RMF de la Saskatchewan en novembre et décembre 2020. Nous avons recueilli des données portant sur les caractéristiques démographiques des résidents, sur la fréquence des incidents de violence dont ils ont été témoins ou victimes, sur les sources des incidents et sur leurs réactions aux incidents. Ces derniers ont été classés comme mineurs, majeurs, graves ou comme actes de discrimination raciale sur la base d'un système de classification existant.

Résultats : Le taux de réponse a été de 34,5 % (38/110). Quatre-vingt-douze pour cent (35/38) des résidents ont été témoins d'un incident mineur et 91,7 % (32/36) en ont vécu un eux-mêmes Soixante et onze pour cent (27/38) des résidents ont été témoins de discrimination raciale, tandis que 19,4 % (7/36) en ont été victimes. Le plus souvent, les auteurs de comportements violents étaient des patients. Vingt-neuf pour cent des résidents ont signalé l'incident à leur superviseur. La plupart des résidents connaissaient la politique de signalement de la violence de l'établissement.

Conclusions : La plupart des RMF de la Saskatchewan ont vécu des incidents violents ou en ont été témoins, mais peu d'entre eux les ont signalés. Cette étude ouvre la voie à une réévaluation des politiques en matière de prévention de la violence, qui devraient tenir compte des sources de la violence et de la confiance des victimes envers le processus de signalement, et prévoir de la formation.

Introduction

Many physicians experience intimidation, harassment, or discrimination during training and independent practice.[1-3] Practicing physicians are often unaware of protective policies, and most do not report or seek help.[4] Similarly, less than 25% of abusive incidents affecting medical residents were reported, despite knowing reporting procedures.[1,2,5] Residents' dependence on supervising physicians can create a power dynamic and encourage abuse.[6] Risk factors for abusive incidents include gender, training status, sexual orientation, ethnicity, culture and language. International medical graduates (IMGs) may experience different abusive incidents than graduates of North American medical schools.

Healthcare professionals who are exposed to (experience or witness) abusive incidents in the workplace report increased anxiety, depression, substance use, a loss of self-confidence and job satisfaction and fear of harm from patients.[2,7-10] The present study sought to provide an opportunity to drive policy changes to ensure a safe learning environment. Specifically, the authors set out to answer the following questions:

1. What was the prevalence and sources of abusive incidents experienced or witnessed by Saskatchewan FMRs, and were these impacted by demographic characteristics?
2. How did Saskatchewan FMRs respond to abusive incidents?

Methodology

Anonymous cross-sectional surveys were distributed to all 110 Saskatchewan FMRs in years 1-3 of training in the 2020-2021 academic year. In November 2020, emails describing the study with a link to a survey developed through the SurveyMonkey platform were sent to FMRs. A final reminder email was sent in December of 2020, indicating a survey closure date of January 2021. Gender, medical school location and residency program were collected using multiple choice questions. Resident self-described their ethnicity. Experiences with abusive incidents were measured on a 5-point Likert scale. The survey was based on published methodology that facilitated comparison to previous studies.[3] Descriptions of the different incident types were provided in the survey and are described elsewhere.[11] Residents' responses to abusive incidents were assessed by providing a list of possible responses and an open-ended 'other' option. Residents were also given an open-ended option to share details of why they did or did not seek help, resources or report abusive incidents.

During data analysis, abusive incidents were grouped into four categories: minor incidents (disrespectful behaviours, bullying, verbal aggression, belittlement); major incidents (physical aggression, destructive behaviour, sexual harassment); severe incidents (physical assault, physical injury, sexual assault) and racial discrimination. Categorization was based on previously published literature[3] and was not presented to residents. Since racial discrimination can take several forms, it was not categorized by severity. Descriptive statistics and the Fisher-Exact test were calculated using SPSS version 27. Bonferroni adjusted p-values were calculated to account for multiple comparisons with each demographic variable. We invited all residents in the program to participate and thus did not calculate an *a priori* sample size. Few residents provided open-ended responses; therefore, detailed qualitative analysis was not performed. However, open-ended responses were reviewed by two researchers to identify relevant quotations.

This project was approved by the University of Saskatchewan's Behavioural Research Ethics Board (Beh ID#: 2209).

Results

The response rate was 34.5% (38/110). Fifty-three percent (20/38), 39.5% (15/38), and 7.9% (3/38) of respondents were in their first, second and third years of training, respectively. More women (63.2%, 24/38) completed the survey than men (31.6%, 12/38). Two individuals did not disclose their gender or identify their gender as 'other.' Most respondents were Caucasian (60.5%, 23/38) and North American graduates (63.2%, 24/38). Respondents were equally distributed amongst urban (50%, 19/38) and regional/rural sites (50%, 19/38).

Ninety-two percent (35/38), 60.5% (23/38), 15.8% (6/38), and 71.1% (27/38) of respondents witnessed a minor, major, or severe incident, or racial discrimination, respectively. Ninety-two percent (33/36), 36.1% (13/36), 2.6% (1/36), and 19.4% (7/36) of respondents experienced a minor, major, or severe incident, or racial discrimination, respectively. The most commonly witnessed and experienced abusive behaviour was disrespectful behavior (Appendix A).

The prevalence of abusive incidents was similar for most demographic characteristics (Table 1). North American Medical Graduates were more likely to experience major incidents than IMGs (50% vs. 0%, p = 0.042). No other statistically significant differences in prevalence based on demographic characteristics were observed ($p > 0.05$).

Patients were a source in almost 90% of abusive incidents, and severe incidents resulted only from interactions with patients (Table 2). Family of patients and supervisors were also common sources of abusive incidents.

Almost 9% (3/34) of respondents considered leaving their program due to abusive incidents. Eighty-six percent (31/36) of respondents were aware of policies regarding abusive events. In response to the abusive event respondents considered: reporting the abusive event to an immediate supervisor (44.1%, 15/34), warning others who may be at risk (35.3%, 12/34), counseling (23.5%, 8/34), developing an escape plan (24.2%, 8/34), attending a workplace violence course (12.5%, 4/34), contacting the police (5.9% (2/34), pressing charges (5.9% (2/34), and obtaining legal counsel 2.9 (1/34). Twenty-nine percent (10/34) reported the abusive event to an immediate supervisor and one respondent used a web-based management system to report an event. Forty-one percent (14/34) warned others who may be at risk, 14.7% (5/34) obtained counseling, and 14.7% (5/34) developed an escape plan. Almost 18% (6/34) of respondents attended a workplace violence course. Another respondent described University policies as a reporting barrier because "the policies themselves are used as a harassment tool […] even [if] an allegation is indefensible under these policies."

Table 1. Prevalence of witnessed and experienced incidents stratified by demographic characteristics.

	Type of incident	Ethnicity			Gender			Medical school location			Residency location		
		Caucasian	Other	Adjusted P-value	Women	Men	Adjusted P-value	North American	Other	Adjusted P-value	Urban	Rural or Regional	Adjusted P-value
Witnessed	Minor *n* (%)	21 (91.3)	10 (100)	1.0	23 (95.8)	11 (91.7)	1.0	23 (95.8)	11 (91.7)	1.0	18 (91.7)	17 (89.5)	1.0
	Major *n* (%)	14 (60.9)	6 (60.0)	1.0	14 (58.3)	8 (66.7)	1.0	15 (62.5)	8 (66.7)	1.0	12 (63.1)	11 (57.9)	1.0
	Severe *n* (%)	2 (8.7)	3 (30.0)	1.0	4 (16.7)	2 (16.7)	1.0	4 (16.7)	2 (16.7)	1.0	3 (15.8)	3 (15.8)	1.0
	Racial Discrimination *n* (%)	17 (73.9)	6 (60.0)	1.0	19 (79.2)	7 (58.3)	1.0	19 (79.2)	7 (58.3)	1.0	14 (73.7)	13 (68.4)	1.0
Experienced	Minor *n* (%)	22 (95.7)	7 (87.5)	1.0	21 (95.5)	11 (91.7)	1.0	23 (95.8)	9 (90.0)	1.0	16 (88.9)	17 (94.4)	1.0
	Major *n* (%)	8 (34.8)	3 (37.5)	1.0	7 (31.8)	6 (50.0)	1.0	12 (50)	0 (0)	.042	5 (27.8)	8 (44.4)	1.0
	Racial Discrimination *n* (%)	3 (13.0)	3 (37.5)	1.0	4 (18.2)	2 (16.7)	1.0	3 (12.5)	3 (30.0)	1.0	3 (16.7)	4 (22.2)	1.0

[a]*To protect confidentially, the demographic characteristics of the individual who experiencing a severe incident is not reported.*

Table 2. Sources of witnessed and experience abusive events.

	Source	Minor, n (%)	Major, *n* (%)	Severe, *n* (%)	Racial discrimination, *n* (%)
Witnessed	Patient	29 (82.9)	23 (100)	6 (100)	22 (81.5)
	Family of patient	20 (57.1)	5 (21.7)	0 (0)	19 (70.4)
	Co-resident	12 (34.3)	4 (17.4)	0 (0)	0 (0)
	Supervisor	28 (80)	3 (13.0)	0 (0)	10 (37.0)
	Co-worker	23 (65.7)	1 (4.3)	0 (0)	12 (44.4)
Experienced	Patient	28 (84.8)	12 (92.3)	1 (100)	7 (100)
	Family of patient	18 (54.5)	3 (23.1)	0 (0)	5 (71.4)
	Co-resident	11 (33.3)	1 (7.7)	0 (0)	0 (0)
	Supervisor	22 (66.7)	1 (7.7)	0 (0)	1 (14.3)
	Co-worker	20 (60.6)	2 (15.4)	0 (0)	0 (0)

Discussion

This study aimed to determine the prevalence of and responses to abusive incidents among Saskatchewan FMRs. The response rate of 34.5%, albeit not as high as we hoped, is comparable with previous studies.[3,4] The greater number of women respondents reflect the demographics of the family medicine program in Saskatchewan, which consisted of 57% (63/110) women during the study.

Only 36.1% (13/36) and 2.6% (1/36) of respondents experienced a major or severe incident during their training, respectively. These numbers are lower than reported by previous authors.[3] However, 60.5% (23/38) of respondents witnessed a major incident, with 15.8% (6/38) witnessing a severe incident.

IMGs had a higher prevalence of experiencing racial discrimination, but witnessed and experienced other abusive incidents less often than North American Medical Graduates. This differs from previous research that showed IMGs and Canadian trained physicians had similar rates of abusive encounters during residency, but IMGs were more likely to attribute their abusive encounters as discrimination to ethnicity, culture, or language.[11] While the cultural background of those trained within North America is diverse, it is possible that cultural differences between these groups contribute to differences in perception of and responses to abusive incidents.[12] A larger confirmatory study accounting for potential differences in perception of abuse incidents would be required to determine if North American Medical Graduates experience a high incidence of major incidents.

Our study's main sources of abuse were patients and family members. The literature reports patients,[2-5,13] physicians, and nurses[11,14] as the main sources of abuse among FMRs. Abuse from individuals outside an organization, such as patients, may lead to safety concerns in the affected individual but a reduced stress response and reluctance to hold the organization responsible, compared to abuse from individuals within the organization, such as a supervisor.[15] These factors may have influenced rates of reporting when incidents involved patients and family members.

Although abuse from patients may be harder to mitigate, there are still several strategies that could be considered. At the time of incident, physicians should ensure the environment is safe, verbalize that the behaviour is unacceptable, outline consequences of continuing or repeating behaviour, stay calm and professional, and treat others with respect and compassion.[16] If abusive incidents are persistent, major, or severe, physicians may consider terminating the doctor-patient relationship, in accordance with the medicolegal requirements of their regulating body.[16] Physicians are generally required to notify the patient and staff of the decision to end the physician-patient relationship, provide a reasonable amount of time for the patient to find a new provider, provide interim care, and be helpful in finding a new physician and transferring medical records.[17] Written harassment policies are another method to mitigate harassment.[18]

Such policies may differ but should outline reasonable and practicable efforts to protect workers from harassment, including third parties such as patients. Reasonable efforts include posting harassment policies in visible areas (e.g., waiting rooms),[18] requiring patients to meet the terms of the harassment policy,[18] and discussions between patients and providers.[19] Reporting is an important response to an abusive incident. One respondent indicated a lack of confidence in their institution's reporting policies. Surveys of resident physicians in Canada between 2018 and 2020 showed that approximately 60% of respondents believed that resources to address abusive incidents at their institution were lacking.[5,14] Another barrier to reporting abusive incidents is the belief that reporting will not improve the situation.[2] Given many abusive incidents were initiated by patients, universities should ensure that third party offenders can be reported in a way that does not violate patient privacy. Given many patient encounters occur outside of university jurisdiction (e.g., in-hospital), universities should work with other system partners (e.g., health authorities) to mitigate harassment.

Education and awareness can help to change behaviours and attitudes toward abusive incidents.[20,21] Mandating completion of the harassment education and awareness courses for employees and residents may increase safety and security in residency programs. These courses are already available at many Canadian universities.[22,23]

In our study, witnessed incidents were up to six times more prevalent than experienced incidents. Thus, witnesses represent the predominant source of underreporting. Individuals exposed to abusive incidents may become angry, and potentially become abusive to others.[24,25] Witnessing abusive incidents can have negative health impacts, and cause lower job satisfaction and increased absenteeism.[26] It is important that individuals exposed to abusive incidents are supported with resources. Institutions should reward residents and faculty members

who respect learners to encourage professionalism and reduce mistreatment of learners.[27]

Limitations

The study's response rate of 34.5% introduces the potential for non-response bias, which occurs when respondents differ from non-respondents in important ways.[28] For example, some residents may not have responded to the survey because they were uncomfortable disclosing their experiences with abuse. Several respondents did not answer certain items, so certain aspects of their experiences would not have been reflected in the analysis. We did not explore the impact of abusive incidents on individuals. Another limitation is the categorization of incidents as minor, major and severe, which was categorized by the researchers based on previous literature as opposed to ascertained from respondents.

Conclusions

Most Saskatchewan FMRs witnessed or experienced abusive incidents during their residency. Although most were aware of how to report abusive incidents, few reported them. Lack of confidence in the management of reported events is one barrier to disclosure. This study provided the opportunity to reassess policies on abusive incidents.

Future studies could assess the impact of education or policy change on the prevalence of abusive incidents. Interviews could explore how individuals' perception of abusive incidents align with the definitions provided in Saskatchewan's harassment policies, and if this impacts our measurement of prevalence of such incidents.

Conflicts of Interest: None

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Appendix A. Additional Tables

Table 3. Prevalence of each witnessed behaviour

		Frequency of events (*n* %)					
Type of behaviour		Never	Rarely	Sometimes	Often	Very often	Weighted Average
Minor	Disrespectful	4 (10.5)	5 (13.2)	25 (65.8)	4 (10.5)	0	2.76
	Bullying	14 (36.8)	7 (18.4)	15 (39.5)	2 (5.3)	0	2.13
	Verbal aggression	10 (26.3)	11 (28.9)	15 (39.5)	2 (5.3)	0	2.24
	Belittlement	10 (26.3)	12 (31.6)	13 (34.2)	3 (7.9)	0	2.24
Major	Physical aggression	18 (47.4)	16 (42.1)	4 (10.5)	0	0	1.63
	Physical aggression and destruction	24 (64.9)	11 (29.7)	2 (5.4)	0	0	1.41
	Sexual harassment	27 (74.1)	6 (15.8)	4 (10.5)	1 (2.6)	0	1.45
Severe	Physical assault	32 (84.2)	6 (15.8)	0	0	0	1.16
	Physical injury	36 (94.7)	2 (5.3)	0	0	0	1.05
	Sexual assault	38 (100)	0	0	0	0	1.00
	Racial discrimination	11 (28.9)	16 (42.1)	7 (18.4)	4 (10.5)	0	2.11

Table 4. Prevalence of each experienced behaviour

		Frequency of events (*n* %)					
Type of behaviour		Never	Rarely	Sometimes	Often	Very often	Weighted Average
Minor	Disrespectful	3 (7.9)	19 (50.0)	10 (26.3)	5 (13.2)	1	2.53
	Bullying	16 (43.2)	14 (37.8)	7 (18.9)	0	0	1.76
	Verbal aggression	12 (33.3)	16 (44.4)	8 (22.2)	0	0	1.89
	Belittlement	12 (33.3)	18 (50.0)	5 (13.9)	1 (2.8)	0	1.86
Major	Physical aggression	31 (86.1)	5 (13.9)	0	0	0	1.14
	Physical aggression and destruction	31 (86.1)	5 (13.9)	0	0	0	1.14
	Sexual harassment	26 (72.2)	7 (19.4)	2 (5.6)	1 (2.8)	0	1.39
Severe	Physical assault	35 (97.2)	1 (2.8)	0	0	0	1.03
	Physical injury	36 (100)	0	0	0	0	1.00
	Sexual assault	36 (100)	0	0	0	0	1.00
	Racial discrimination	29 (80.6)	6 (16.7)	0	1 (2.8)	0	1.25