

SHORT COMMUNICATION

## ENSURING SAFETY OF OUR YOUNG DOCTORS-A TIME FOR ACTION

Ganesh Ramachandran<sup>1</sup>, Aung Ko Ko Min<sup>2</sup>, Munandy Alagar<sup>3</sup>

<sup>1</sup>Faculty of Health and Medical Sciences Taylor's University MALAYSIA

<sup>2</sup>Faculty of Medicine Bioscience and Nursing MAHSA University MALAYSIA

<sup>3</sup>Faculty of Medicine and Health Sciences UCSI University MALAYSIA

**Corresponding Author:** Ganesh Ramachandran, Faculty of Health and Medical Sciences Taylor's University MALAYSIA, **Email:** ganesh.ramachandran@taylors.edu.my

### INTRODUCTION

The issue of safety of young doctors in Malaysia is a recurrent issue, in recent years there have been more reports of bullying and harassment at the workplace which is a cause for concern. About a year ago an incident involving the unfortunate death of a house officer and the subsequent claims of the hospital being the worst place to practice has once more pushed this issue to the fore resulting in a high-level committee investigating the matter and providing recommendations to ensure the wellbeing of junior doctors. While changes were affected, other similar allegations have surfaced.

These problems however are not unique to Malaysia. They have and continue to be well documented in all healthcare facilities the world over.

As educators and practitioners, we are major stake holders in any process involving the profession and it is important that we begin to think about strategies to address this issue holistically and prevent any further incidents of this nature. The other issue that needs study is if these are isolated incidents or if there are systemic defects in the process that have gone unattended. We all believe that most people in the profession do not subscribe to this behavior, however it does exist and must be acknowledged.

To consider this problem holistically we need to look at the magnitude of the problem and viable solutions for the doctor in training, the trainers, and any other party with a stake in the outcome.

**KEYWORDS:** Safety, Young Doctors, Harassment, Solutions.

### MAGNITUDE

While it is recognized that workplace harassment is a problem internationally the exact prevalence is hard to pin down with figures ranging between 30 to 95% of junior doctors across the globe reporting having been bullied. A local study published in 2021 reported the incidence of bullying among house officers who had completed at least 6 months of training at 13% In this study having graduated in an Eastern European medical school, working in a Surgical (Surgery and Orthopaedics) discipline and poor English language skills increased the risk of being harassed. Medical Officers were most likely to be the perpetrators followed by nurses and support staff. There were no significant differences in age, gender, and ethnicity in the Malaysian study, but many studies

indicate that younger doctors, female doctors, and doctors from minority groups are at increased risk. (1,2)

A study in the United Kingdom in 1999 involving a cohort of 1100 in an NHS community revealed a 70% prevalence of bullying in the previous year (2). A similar study in India, involving 174 doctors indicated that almost half had been subjected to bullying and the perpetrators were medical personnel and paramedical staff. The incidence of bullying among interns was as high as 89% (3).

Systematic harassment is defined as a repetitive process that is intimidating, abusive and offensive which leads to impairment of learning, work, performance, and advancement. (8) It tends to lead to increased risks of depression, attrition, and suicide risk with a negative

impact on patient safety and more workplace errors and accidents. (4)

The factors that have been identified as promoters of such behavior are the perceived hierarchical structure in the practice of medicine, the grueling training process, the passive acceptance of such behavior as a functional education tool and the culture of silence in reporting such behavior for fear of recrimination. (2) This has been seen repeatedly in many studies the world over. In the Indian study up to 20% were not sure of how to complain and were afraid of the consequences. (3)

In 2015, following a warning from a Vascular surgeon in Sydney that for the sake of their careers, women were better off giving in to sexual advances from superiors instead of resisting or complaining, the Royal Australian College of Surgeons appointed an expert advisory committee to investigate the allegation. The ensuing report found that at least 50% of the respondents reported having experienced bullying, discrimination and sexual harassment with senior staff being principal perpetrators. Again, reporting was considered “career suicide” Being female and young increased the risk. (5) This is perhaps an indication of the pervasiveness of this problem and lends credence to the findings from the United States that the bullying began in medical school and extended to the training years. (1)

### COMBATING THE PROBLEM

There is a pervasive undercurrent of bullying and harassment in the medical workspace, and it is often accepted as a rite of passage in training often disguised as an ability to work under pressure. It is clear also that these do not have positive outcomes and endanger both physician and patient wellbeing. As such it is important to incorporate strategies to prevent bullying to ensure good outcomes.

The most important of these is to increase awareness of what entails bullying, how to report it. There should be access to wellbeing resources that emphasize emotional quotients, honest communication, leadership skills, empathy stress relief and conflict management. Exposure to interdisciplinary activity and team-based care at all levels will break the cycle of hierarchy that has dominated medical education and training. The reporting mechanism must also be anonymous with a committee that will review each complaint, while clearly indicating standards

of acceptable behavior and the penalties if these are breached. (6)

There must also be access to confidential mental health services to identify those at greater risk and the provision of processes to identify bullying and harassment in the workplace.

The Lucian Leape Institute for medical education advocacy suggests the following solution:

Medical school and teaching hospital leaders should place the highest priority on creating learning cultures that emphasize patient safety, model professionalism, enhance collaborative behavior, encourage transparency, and value the individual leader; eliminate hierarchical authority gradients that intimidate others and stifle teamwork; demonstrate non-tolerance for abusive or demeaning behaviors; enforce a zero-tolerance policy for confirmed egregious disrespectful or abusive behaviors. (7)

Program directors and Heads play a significant role in ensuring that mechanisms are in place to combat harassment. There must be a distinction between simply attending, teaching, and being taught. The former is a hierarchical concept and refers to a one-sided transmission of knowledge, while the latter emphasizes a team-based effort, accepting feedback and a team-based effort in patient care. This would reduce the risk of harassment and allow younger doctors to ask for help without being taught of as weak or lacking in skills. (6) There must be clear expectations of what constitutes acceptable behavior and harassment, either racial, sexual, or online, there must be mechanisms that educate the work force on workspace wellness, psychological safety, and overall wellbeing. Finally, there must be clear and defined pathways for intervention and reporting of harassment situations that are transparent. (7) This will protect all stakeholders.

A larger question that may also be important is to recognize that we need to build resilience into the psyche of our young health professionals so that they will be able to call out a wrong and work together for a better workspace environment. This must begin as early as possible so that our young doctors have the skills to

Build good relationships with their peers and superiors.

Develop independence while recognizing the importance of teamwork.

Identify, manage, and express their emotions appropriately.

Take on personal challenges and triumph over adversity. (8)

Resilience will ensure that we develop a new generation of doctors who are congenial, confident, and competent.

In conclusion we must accept that harassment exists in our workspaces and that it has largely been ignored or ridiculed when brought to the attention of the authorities.

We must create clear guidelines for what is accepted as good workspace conduct. We must have mechanisms to report perceived breaches in this conduct and have transparent mechanisms to deal with them. We must emphasize the importance of inter disciplinary cooperation and teamwork for good outcomes and build resilience in our young doctors so that they can withstand the rigors of training and the workplace while being ready to call an injustice or unethical behavior that may pose a danger to themselves or a colleague.

*The following table summarizes the problem in a Malaysian context, (what has been done and what needs to be achieved if we are to surmount the problem). It is based on a reading of the problem by the authors and is our collective opinion.*

The Problem and Solution	What Has Been Done in University	What Needs to Be Done	What Has Been Done in The Workplace	What Needs to Be Done in The Workplace
<p>A gap in competencies in the junior doctor results in inferior performance or outcomes. This needs to be addressed and solved. There must be clear methods of reprimand and avenues of retraining to address the gap and to ensure competency within a suitable period. This must be educative and supportive. It should not be linked to gender race or religion.</p>	<p>The Malaysian Medical Council has a document that sets standards for undergraduate medical education. The most recent revision sets out the core competencies that need to be achieved at graduation. (9) This will align requirements and standards needed for junior doctors joining the work force</p>	<p>Introduction of a common exit examination for all Malaysian undergraduates and junior doctors entering the work force from medical schools overseas designed to meet local needs. The Malaysian Dental Council have implemented this. Moves to do the same for the undergraduate medical programme have been suggested.</p>	<p>Structured logbooks for house officers with milestones to be met for various competencies and assessment of these are in place</p>	<p>Educating young doctors to recognize and call out systematic harassment. Building resilience to withstand stresses of the profession among young doctors. Breaking hierarchal barriers and building the concept of teamwork in hospitals. Clear standards of acceptable behavior must be put in place to prevent harassment. Supervising doctors must understand that comparisons of how it was in the past will not improve outcomes. At the end of the day change is constant and we all need to recognize this. We need to build an understanding that gaps exist, competencies may be wanting among junior doctors. There may be many reasons for this. Reprimanding and correcting with reassessment to achieve a level of competence is not wrong but it should never be tied to elements of gender, race, language competency, place of qualification or age.</p>

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