What 'Learning by Shame' Does to Young Doctors

BY GINA SHAW

Emergency physicians don't have the highest rates of depression among doctors; that dubious distinction belongs to neurology, in which some 55 percent of specialists report experiencing depression, burnout, or both.

But emergency medicine isn't far behind at 48 percent, according to the Medscape Physician Lifestyle Report for 2018. (https://wb.md/2Ydc6ZN.) Across the board, these high rates of depression translate into an increased risk for suicide. A study published in the *American Journal of Psychiatry* found that female physicians are more than twice as likely to die by suicide than women in general. (2004;161[12]:2295; http://bit.ly/2UK5Cj2.) The rate is 1.4 times higher for men. Overall, the suicide rate among doctors is higher than that found in any other profession, including stressful careers like the military and law enforcement. (Medscape. May 7, 2018; https://wb.md/2OiEGED.)

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This level of depression and stress starts early in a physician's career. One study found that 9.4 percent of fourth-year medical students and interns reported having suicidal thoughts in the two weeks previous to the survey. Suicide is the second most common cause of death after accidents among medical students. There's a relative paucity of research on depression and burnout specific to emergency medicine residents, but one study assessing clinical depression at four emergency medicine residency programs found that 12.3 percent of residents had experienced a possible major depressive episode in the previous year. (*Acad Med*. 2009;84[2]:236.)

Considering the stigma attached to physician suicide and mental health issues, these numbers probably represent a significant underestimation of the true picture, said Pamela Wible, MD, a family physician who operates a suicide hotline for physicians and has a registry of more than 1200 physician suicides. Emergency physicians rank third in suicide rates among active physicians per specialty, behind only anesthesiology and surgery, in her database. (http://bit.ly/2Oh1k0e.)

Many factors contribute to these high rates of emotional problems among young physicians, but experts say one is a culture of shame and humiliation that persists as part of the medical school and residency teaching environment, even as institutions enact policies and systems aimed at instilling a more connected, less judgmental approach to teaching.

Old School

"Fear-based training was historically used to motivate students to learn, which seems so counterproductive today," said Dr. Wible. "But this is still going on at some brand-name medical institutions. Even if a school is progressive, they may still have people in power positions who are very old guard in their teaching methods. If you're the head of neurosurgery and you were taught with terror-based teaching, you feel like that's what made you a good doctor and it's your job to scare the people underneath you so that they stay on top of things."

Behaviors like throwing scalpels across the room or screaming at a resident until he breaks down in front of patients may be relatively uncommon today compared with two or three decades ago (although still not unheard of), but they've been replaced with others that are less dramatic but still likely to induce shame and humiliation in young physicians. Investigators from Duke University School of Medicine and the Uniformed

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Services University chronicled some of these behaviors and their impact on medical residents in a study published recently in *Academic Medicine*. (2019;94[1]:85; http://bit.ly/2Tm1Z1g.)

"Asking repetitive questions over and over again with the purpose of showing the learner that he or she doesn't know anything, as opposed to Socratic questioning, with the intent to stimulate active thinking and identify contours of knowledge" is one such example, said lead author William Bynum IV, MD, an assistant professor of community and family medicine and an associate program director of the Family Medicine Residency Program at Duke.

Another example, he said: "Morbidity and mortality conferences that feel like a trial, putting the person in front of a group where they are hammered for mistakes that are made in ways designed to make them feel globally deficient."

Dr. Bynum said one resident in their study missed a critical lab value, resulting in a patient getting very sick, being transferred to the ICU, and later dying. "One of the fellows caring for the patient called the resident at home in the middle of the night to say, 'You missed this, and the patient coded.' It was a completely inappropriate way to deliver devastating news, and it worsened the shame the resident was already feeling. Someone yelling at you, calling you names, putting you down is likely to shame you, not help you focus on specific things that could be improved."

'The Dumbest Person Here'

Dr. Bynum's study recruited 12 internal medicine residents from a large teaching hospital to write about an experience during medical training in which they felt "flawed, deficient, or unworthy" and to participate in a semi-structured interview that explored their shame experience in depth. "The data were analyzed according to hermeneutic traditions, producing rich descriptions about participants' shame experiences," he and his colleagues wrote.

Participants recalling these shame experiences labeled themselves as deficient, undeserving and inadequate, not smart enough and the dumbest person here, the worst, unlikeable and inferior, and flawed and like "there's something wrong with me."

"One participant recalled a shame reaction that was 'absolutely debilitating for several hours where I was a completely different person,' and another felt 'like I was swimming in my own body,'" the authors wrote.

Treatment by supervisors played a major role in shame reactions. "A participant struggling on his first ICU rotation encountered harsh treatment from a fellow who 'picked on' and 'crucified' him on patient rounds in response to his obvious struggles," Dr. Bynum and his colleagues wrote. "This significantly heightened the shame he was already feeling from his perceived low performance on rounds. He went on to recount the effects of a toxic, 'psychologically unsafe' environment created by the supervisor: 'I think we were all afraid of her [the supervisor]. She'd come into the team room and [be very rude], very short. So I don't know if there was a lot of learning going on those two weeks and more a lot of fear of getting yelled at or fear of not having the right lab.'"

A culture of humiliation that persists as part of medical school and residency teaching contributes to emotional problems among young physicians

These experiences of shame and humiliation, Dr. Bynum said, led to social isolation and an impaired sense of belonging, loss of motivation to learn, diminished psychological and physical wellness, reduced self-regulation, unprofessional behavior, and impaired empathy.

"All these outcomes matter," he said. "They don't just matter from a wellness standpoint, although these markers of impaired wellness can be pretty profound, but there also appears to be a significant effect on learning, and that's where there's real weight in this phenomenon. Shame may impair development of competence in addition to well-being."

Guilt, Remorse, Distress

The study focused on internal medicine residents, but Dr. Bynum speculated that a similar assessment of emergency medicine residents could yield even more intense experiences of and reaction to shame and humiliation during learning. "We found that major medical errors that harmed a patient were the strongest shame triggers of all, and in a high-stakes, fast-paced environment like emergency medicine, these triggers may be especially prevalent," he said.

Cherri Hobgood, MD, the Rolly McGrath Professor and Chair of the Indiana University School of Medicine Department of Emergency Medicine, agreed with his assessment. "In the context of the ED, there are a lot of things happening all the time and a lot of potential distractions. At any given time, you are dealing with multiple challenges, thought processes, and a different amount of content expertise in a given area a patient may be presenting with, and bad outcomes can occur. I've had both residents and faculty come to me to talk about the fact that they're struggling to 'fit in'—to handle the volume. The pace of our work is so extreme that it can really diminish younger residents' and junior faculty members' confidence in themselves."

Dr. Hobgood published a study in 2005 assessing emergency medicine residents' emotional and behavioral responses to their own medical errors. They found that negative emotions such as anger, guilt, remorse, emotional distress, frustration, and inadequacy were common responses to errors, and that these negative responses were often associated with institutional factors such as an unsupportive institutional environment and M&M conferences that exacerbated their sense of wrongdoing and incompetence rather than fostering open discussion and professional modeling of error acknowledgement.

"We need to do M&M conferences in a way that makes them less punitive, so that people feel less under the gun personally," Dr. Hobgood said. "That's what we try to do at IU, with a systems-based approach to M&M that is not individually focused. We also provide a lot of training for all our incoming junior faculty on how to give feedback in a way that allows the person to receive the information in a constructive manner."

Another study by Dr. Bynum and his group reported on the experience piloting a shame seminar" for second-year clerkship medical students designed to foster resilience to shame. (*Acad Med.* Feb. 5, 2019, Ahead of Print; http://bit.ly/2uh6Iat.) A large group session to introduce the psychology of shame was followed by a smaller one for students to discuss their reactions to the large group content in a safe and familiar environment.

Pre- and post-surveys identified "statistically significant increases in students' confidence in identifying shame and differentiating it from guilt; in their attitudes regarding the importance of identifying shame reactions in themselves and others; and in their willingness to reach out to others during a shame reaction."

Dr. Bynum and his group plan to take this seminar further and develop an empirically-derived, longitudinal shame resilience curriculum spanning the medical school and residency years.

"We need to change the overarching culture of medicine and medical training," he said. "We can't be a culture that tolerates behaviors that are likely to shame. If we hope to achieve safe, compassionate patient care by training doctors who are competent, empathetic, well people, we need to fundamentally change the training and work environments that are counter to that mission." **EMN**

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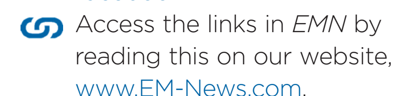
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