Long Hours, Insulated Specialties Result in Lateral Violence in Residency

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EDITOR'S NOTE: This is part one of a two-part series about lateral violence in residency training. The second installment will appear in the October issue of *AAOS Now*.

Lateral violence has been described in nursing as a peer-directed variant of bullying. People under stress or in adverse situations often redirect frustrations onto their peers. Lateral violence can take many forms, including complaints, commiseration, work sabotage, or efforts to gain position or control over a coworker.

When hours are long and work requirements are voluminous, the environment is ripe for such activities. A labor shortage in any given field can certainly heighten the problem. In nursing, there are many openings and too few nurses. Warm bodies that show up to work are often not fired for misbehaving. When staff members are not disciplined for bad behavior, others may feel empowered to use lateral violence to their own advantage.

This article explores the ways lateral violence may occur in residency training, provides examples from residents in training, and discusses the potential negative effects on residency programs, as well as corrective measures. Alan M. Reznik, MD, MBA, FAAOS, moderated a discussion with Julie Samora, MD, PhD, MPH, FAAOS; Paul Saluan, MD, FAAOS; Erin Cravez, MD; Deepak Ramanathan, MD; and Courtney Toombs, MD, about the problem as it applies to orthopaedic residency programs.

Dr. Reznik: Dr. Samora, can you give an example of how a residency workforce shortage caused lateral violence?
Dr. Samora: After undergoing major knee surgery and dealing with a complication, a resident was under a lot of pressure to make up missed calls.

She confided, "I walked into the call room as a second-year resident, and there was a page-long email written by one of my classmates that spelled out why I did not deserve to be a part of the class. They were plotting with others about how to get me kicked out by first going to the chief residents and then to the program director." This was "all because I was out of the call pool for a few months to recover from surgery."

Was the resident planning for the time off and how to make it up?
Dr. Samora: Yes, she noted that the original plan was to take a year off to have the surgery and recover. As it turned out, ironically, she was asked back early to "help out" due to the loss of another resident who was placed on probation.

Dr. Cravez, you have experienced lateral violence from another direction during your training.
Dr. Cravez: Our orthopaedic residents typically take emergency department consults for 28-hour shifts (more or less) every two to four days and on busy summer days might be consulted on 30 or more patients, including time-consuming polytraumas with reductions, splints, and traction pins. We triage and prioritize these consults to best manage our time. The emergency residency has a set 60-hour work week, and residents work in eight- to 12-hour shifts. We tend to view those residents as more well-rested and able to self-limit their patient loads. Many emergency residents and physician's assistants have limited exposure to orthopaedics, and we are commonly the first-line consult for any musculoskeletal complaint, including simple sprains. Stretched, we view the minor injury consults as inappropriate while we tend to more acute patients. This may come off as stressed or terse responses on the phone. Lacking orthopaedic knowledge and genuinely unsure of what to do, they view our service as dismissive or even rude. Later, the residents admitted they were unaware of the length of our surgical consult days and total volume of calls, assuming they were similar to their own. Still, discrepancies in patient volumes, hours, and workloads can lead to animosity between services.

Do you think this translates across all services or just those that act as consultants to others?
Dr. Cravez: We do relate more to the other surgical services because their hours and volumes are more similar to our own. Even so, each specialty tends to become more insular. We act as if only our fellow residents can relate to our own experiences and frustrations. In some ways, this promotes comradery and team building within our own cohort, but I'm sure it also contributes to lateral violence toward other specialties.

Dr. Saluan, do you think Dr. Cravez's experience is a new problem because of work rules or something that has echoed through programs over time?
Dr. Saluan: This behavior has probably been around for a while. I wouldn't be surprised if there was lateral violence within the prehistoric hunter-gatherer societies. In modern, more familiar settings of our healthcare system, I believe this human tendency is exacerbated by various unique stressors such as a litigious environment, complex electronic medical record demands, and new work-hour rules. For example, during the early implementation phase of the Accreditation Council for Graduate Medical Education-mandated work-hour restrictions, senior residents grumble about how the more junior residents are now "coddled," and they express resentment over the changes in the call schedules. In many orthopaedic residency programs, these changes in call schedules came at the expense of the senior residents, who took more "junior-level" calls to fill the gap. Therefore, it should not be surprising when senior residents direct their frustrations about new work-hour rules toward more junior residents via lateral violence.

Dr. Samora, how does a resident manage to avoid work and still pass through the system?
Dr. Samora: I remember a resident who entered our class from a research year. He absolutely met the criteria for lateral violence. He refused to take any holiday calls; he would have the intern or night-float resident place all of his orders and perform histories and physicals on his spine patients (they were not even on that service). He was a smooth operator with attendings (like a used-car salesman) and generally was a selfish, nonteam player.

Dr. Samora, have you changed anything in your program to deal with this type of problem going forward?
Dr. Samora: Because of him, as a resident, I implemented a 360-degree evaluation system. It is similar to the one that Jack Welch developed for General Electric, where each level reviews those above, those below, and peers. It gives a fuller view of cooperative work ethos for each resident and is still in use

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Part 2 available online now!
You don't have to wait until October to read part two of this editorial. Visit www.aaos.org/aaosnow to read it now.

Bullying and lateral violence in the medical field

A work climate that enables bullying, harassment, discrimination, and microaggressions can negatively affect a person's health and career.

Why is the medical field at risk?
- hierarchical structure
- "code of silence"
- fear of retaliation

The systematic abuse of power:
- abusive conduct akin to psychological violence characterized by threatening, humiliating, or intimidating actions or words

The results of lateral violence:
- increased turnover
- decreased teamwork
- higher baseline of anxiety/chronic stress
- increased "lateral violence"
- "toxic culture"
- loss of joy in medicine

Medical students' experiences:
- 42 percent of U.S. medical students have experienced harassment.
- 84 percent of U.S. medical students have experienced belittlement.
- 20 percent of first-year medical students in the United Kingdom have experienced bullying and harassment.
- 74 percent of Australian medical students have experienced shaming during teaching.

ADAPTED FROM THE LECTURES OF JULIE SAMORA, MD, PHD, MPH, FAAOS, ON BULLYING

Much Has Changed With ABOS' Computer-Based Recertification Examinations

MICHAEL S. BEDNAR, MD

In the spring, more than 9,500 Diplomates of the American Board of Orthopaedic Surgery (ABOS) took part in the inaugural Web-Based Longitudinal Assessment Program (ABOS WLA). It was a successful launch, and the ABOS looks forward to its growth. However, many ABOS Diplomates want to take only one assessment every decade and are happy with the numerous options offered with an ABOS Computer-Based Recertification Examination (CBRE). The ABOS has made several improvements to the Examinations over the past four years.

The ABOS now offers CBREs that are practice-profiled in the following subspecialties:

- general orthopaedics
- adult reconstruction
- foot and ankle
- orthopaedic sports medicine
- orthopaedic trauma
- pediatrics
- shoulder and elbow
- surgery of the hand
- spine

The ABOS added the shoulder and elbow practice-profiled CBRE to its offerings this year and added trauma, pediatrics, and foot and ankle two years ago. Previously, orthopaedic sports medicine and surgery of the hand recertification options were available only to those who held an ABOS Subspecialty Certificate. Now, any ABOS Diplomate can take these Examinations to recertify their orthopaedic boards; however, Diplomates can only earn Subspecialty Certification by meeting the specific requirements. Most Diplomates can now find a CBRE in their subspecialty.

Each CBRE consists of 150 multiple-choice questions pertinent to practicing orthopaedic surgeons focused only in that subspecialty. Previously, in addition to the subspecialty questions, all subspecialty exams also had 75 general orthopaedic questions. Feedback from Diplomates was that Examinations should truly be practice-specific and include only questions pertaining to the applicable subspecialty. The group of general orthopaedic questions is no longer a part of any Examination.

You can see a breakdown of the topics covered on each Examination by visiting www.abos.org and reviewing the Examination Blueprints, which are found in the MOC (Maintenance of Certification) section under Examination Options. When an orthopaedist is preparing for a CBRE, the ABOS highly recommends that he or she review the Examination Blueprint and focus on reviewing the areas emphasized there.

The Examination Blueprints are developed by practicing orthopaedic surgeons who were nominated to participate by AAOS and the appropriate subspecialty societies. For each subspecialty blueprint, the group met at the National Board of Medical Examiners offices in Philadelphia to consider what an orthopaedic surgeon in that subspecialty needs to know to practice competently and safely. Blueprints are developed based on numerous factors, including data from the ABOS Case List Database, which contains relevant information on the types of surgeries orthopaedic surgeons are actually performing. The Examination Blueprints are reviewed regularly to keep up with changing practice patterns and new developments in the profession.

Another change the ABOS has made is to move all CBREs to August and September, starting this year. Previously, most were given in the spring. The ABOS WLA is now given in the spring, whereas the ABOS Oral Recertification Examination—another option—is given each July.

The ABOS continues to make the recertification Application process easier. Diplomates are encouraged to complete the Application in year seven of the MOC cycle, but it also can be completed in years eight or nine. An Application and Case List are required regardless of the recertification pathway. The Application has more pre-printed information and is quicker to complete than in the past. The Case List, which is part of the Application process, also has been streamlined, resulting in less time required for completion. Also, Diplomates now have to enter only 75 consecutive surgical cases, starting with the first surgical case of the Application year, regardless of the pathway. The next Application deadline is Dec. 2 for those Diplomates whose certifications expire in 2020, 2021, or 2022. The ABOS highly recommends that Diplomates apply in the first year eligible to maximize assessment opportunities.

The ABOS highly recommends that orthopaedists take time before the exam to review the Examination tutorial, which demonstrates how the interface works and gives additional break time during the Examination itself. Once a recertification Examination has been taken, the ABOS strives to release the score as quickly as possible. There is a process in place to ensure that all Examinations are valid and reliable, producing scores that are scalable each year. The ABOS does that by working with psychometricians who summarize the statistical performance of each question. Then, a Key Validation Committee reviews the data. Poorly performing questions are removed before scoring. Psychometricians also analyze the degree of difficulty for each question and the Examination overall.

Next, the ABOS Written Examination Committee uses that information to set the cut score—the pass/fail point. The ABOS does not set an overall pass rate (percentage of people who pass/fail)—just the cut score, which is designed to produce the same likelihood of passing or failing no matter when the Examination is taken. The ABOS website shows the pass rate for each practice-profiled CBRE.

Many of the changes the ABOS has made are based on Diplomate input and feedback. The ABOS encourages orthopaedists to provide feedback whether using formal methods like surveys, contacting the office at 919-929-7103, or emailing a Certification Specialist. Their contact information can be found on www.abos.org; click "Contact." The ABOS staff is always eager to help Diplomates understand their options.

The ABOS thanks all of the volunteer orthopaedic surgeons who help with developing the blueprints and writing and reviewing the Examination questions. Although many volunteers have been with the organization for years, the ABOS is always looking to increase its pool of volunteer subject-matter experts. To volunteer, go to www.abos.org and log in to your ABOS Dashboard. There is a button that takes you the volunteer form and provides information about each opportunity. Filling out that form will put your name on the ABOS Volunteer List.

Michael S. Bednar, MD, is chair of the ABOS Written Examination Committee.

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today. It allows residents to evaluate fellow residents, and it enables attendings to be aware of resident "shenanigans."

Dr. Saluan, have you seen adjustments in your program evaluations or processes that also can help avoid this type of behavior?
Dr. Saluan: Like part of the 360-degree review, some nonorthopaedic programs conduct peer evaluations where interns and junior residents submit formal feedback about their senior residents. This becomes part of each resident's professional portfolio that may be accessed by attendings and human resources at any time in his or her career. The majority of these tend to be constructive and appreciative in nature. Still, on occasion, program directors come across some troubling evaluations. In one case, a male junior resident gave his female senior resident a poor evaluation, stating that she was "bossy" and difficult to work with. On further research, the service attending noted that the junior resident had significant deficiencies and was responding in a poor manner to reasonable criticism. There was also the question of sexism in that particular case.

References for the studies cited can be found in the online version of this article, available at www.aaos.org/aaosnow/19074.

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