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Experience

The Shame Is Not Mine: Addressing Abuse of Power Dynamics in Medical Training

Sierra Norman.[1]

The Experience

The concept and concern about mistreatment during medical school is a longstanding issue. In the early 1980s, a physician on faculty at a medical school noticed the stark contrast between the optimism and eagerness in incoming medical students and the cynicism and depression of graduating medical students.[1] His subsequent research revealed that medical student mistreatment, particularly during the clinical years, led to this significant and negative impact.[2] In 1991, the Association of American Medical Colleges began including questions about mistreatment in their annual Graduation Questionnaire.[3] Numerous studies have been conducted on best practices to address medical student mistreatment. In 2012, the David Geffen School of Medicine at UCLA published their results after analyzing 13 years of data on the incidence, severity, and sources of perceived mistreatment.[4] During this period, they had implemented multiple approaches to address medical student mistreatment, including creating formal and informal methods for reporting and resolving incidents, providing education on the topic to students, residents, and faculty (i.e. definitions of mistreatment), and promoting open discussion among all levels. Despite these efforts, there was no significant change in the culture of mistreatment, citing influence of the engrained "hidden curriculum" of unspoken norms in the academic-social environment.

My experience with mistreatment occurred on a surgery clerkship. Surgery clerkships have the highest rate of reported mistreatment from medical students, with faculty typically being the source.[5] Across all specialties, mistreatment of medical students is largely due to sex/gender, race/ethnicity, and sexual orientation.[3] The American College of Surgeons has recognized the problem of mistreatment within their specialty specifically, which uniquely also includes influence of student role and career choice.[6] This suggests individualization of mistreatment, which creates additional obstacles to relying solely on a generalized response to mistreatment.

An important part of responding to mistreatment is being aware it exists. However, many students do not feel comfortable reporting mistreatment. Common reasons include concerns about believing it was not significant enough, mistrusting their institution, and fearing retaliation.[7,8] And, unfortunately, these concerns are often justified.

My First Surgery Clerkship

I have carefully considered the decision to share my surgery clerkship experience. Having already faced retaliation and defamation for voicing my concerns, I worried that sharing publicly might further affect my future education and career. However, staying silent about this specific experience would make me feel like I am accepting the shame of it. But the shame is not mine.

During the summer of 2023, I began my third core clerkship in surgery. My approach to every core clerkship has been to make the most of my experience, realizing I may never do anything like it again. I knew there were stereotypes of the environment, but my approach to surgery was no different. However, the atmosphere was far worse than I could have ever anticipated.

The initial negative interactions were primarily with the physician assistants (PAs). I want to preface that these experiences were with individuals, not a profession. I have worked with some incredible PAs whom I admire and am grateful for their contributions to my medical education. During this clerkship, I was predominantly left to work with the PAs, and there was tension with them from the beginning. I was told incorrect times to arrive to cases, misdirected on which cases to participate in, and directly rejected when I tried to ask for help or clarity on expectations. I was not scheduled to participate in clinic with the attending physicians, being told "medical students slow things down," so my only interactions with them were in the operating room. During the end of one case, an anesthesiologist felt it necessary to step in on my behalf and diffuse a PA's mistreatment towards me after the attending physician had left. The expectations from the PAs often contradicted the document on medical student expectations that I had received from the site director. No matter how I tried to balance it, tensions continued to escalate. I have included the timeline of the negative interactions submitted to my university as a Supplementary file, highlighting two of note below.

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During Week 2 of 6, my interactions with the PAs had escalated to the point that I was concerned about their influence on my evaluation. I addressed this concern with the site director, who dismissed it. He reassured me that he was not worried about it impacting my evaluation and that I should not be either. He attempted to normalize tension within their surgical team by sharing some of the drama. Such as issues with a PA taking a "father-like" approach with students. And the practice needing offices on two separate floors due to contempt between some of the surgeons. And a surgeon writing inappropriate notes, like referring to a patient's pre-procedure shave as a "pornstar shave." He finished the conversation by advising me to keep trying with the PAs.

During Week 3 of 6, I was publicly humiliated for the second time by a PA, this time in front of the patient, a new attending physician, and the rest of the surgical team in the operating room. He continued to accuse me of skipping rounds, even after a brief explanation that I was not assigned to participate that morning. It was not the time or place to argue, so I waited until the next morning and asked to speak with him privately about it. I told him I was on the clerkship for my education first and foremost and would not intentionally skip opportunities. I acknowledged there was some confusion the day prior and asked if he had any concerns about my performance moving forward that he address them with me directly. Initially, he was receptive, then he abruptly started yelling. "Actually, I am upset now. I have never been called out by a medical student before. Do you want me to just ignore your existence? Because I can do that!"

After speaking to the site director about this interaction, he made adjustments to limit the PAs interactions with me. However, the negative encounters and toxic environment still continued. With about two weeks remaining in my clerkship, the site director completed my Mid-Rotation Student Feedback Form, giving me positive marks and indicating no concerns. He also mentioned several times that the other attending physicians had texted him that they had had a good day with me in the operating room. On my last day, I offered to discuss my clerkship experience with him, hoping for some follow-up about the environment. He did not accept but texted me that I "finished strong." I let him know I had a timeline of the negative interactions that occurred and would include it in my evaluation to the university, for the sole purpose of providing feedback to improve the learning environment for future students. He told me again that he was not worried. And I was simply relieved for the clerkship to be over and my break to be starting.

But It Only Got Worse

I wish I could say that the negative experience ended with the conclusion of the clerkship, but it only got worse. The knowledge of my timeline triggered retaliation from the site director, to a level of severity the university's designated advocate and other faculty members say they have never seen before. I mistakenly received an email from the site director intended for his colleague, stating he believed I would be giving him a negative evaluation and he would be failing me.

A few days later, I received the site director's evaluation, with a clinical grade of 34.1% (FAIL) and a comment stating, "it's a matter of time before she hurts a patient."

As an individual who made the choice to dedicate my life to a career helping people, receiving this comment was absolutely devastating. The days and months that followed left me to fall into a very dark place. For so many reasons, I struggled to share anything with anyone. The weight of it felt so heavy, I did not want to crush anyone else. I tried to keep the darkness to myself, but it was slipping through the cracks. And it broke my heart to watch as my behavior was misrepresented by my closest friends and twisted into damaging rumors, shredding the last bit of reputation I had and leading to more self-isolation.

I did make a half-hearted attempt to seek help. But when the university's counselor did not show up to our appointment, it just reinforced my belief that it was not that bad and I could handle it on my own, so I did not pursue further support. I knew I was not going to do anything, so I did not think I needed to tell anyone. I did not think I needed to tell anyone that my Juliette balcony seemed to taunt me with its symbolic and ironic possibility. I did not think I needed to tell anyone that I used to sleepwalk when overly tired and stressed. And that maybe fear of that led to waking up being unable to move, feeling like I was being choked by a shadowy creature. But mostly I did not say anything because I did not want anyone to think I was weak. And as a result, my body became weak.

I was not talking. I was not eating. I was not sleeping. I was having multiple panic attacks a day. And eventually that all caught up to me. I accidentally ate something I was allergic to, something that I have done dozens of times with only a mild reaction. This time, I thought I was just having an XL panic attack at the same time and practically begged for over an hour just to be left alone to go to sleep. By the time I let someone take me to the emergency room, my oxygen saturation was 77% and I was showing signs of stage 3 anaphylactic shock. The doctor gave an incredulous, but kind, lecture to this medical student, telling me that if I had gone to sleep, I would have woken up with brain damage, if I woke up at all. Being disturbed with thoughts of not existing anymore for weeks, and then having my actions almost unintentionally result in that, was such a violent wake-up call.

Starting To Heal

I was emotionally, mentally, and physically shattered, but I was alive. After my break, I started my Internal Medicine clerkship. As I was shown compassion and started to feel safe again, I slowly began sharing what I was going through. When I confided in my attending physician, she began to cry and shared something similar had happened to her during her surgery clerkship decades ago. She was promised the culture was not always going to be like this, but here it was still happening. Then she said something that brought on a fresh set of tears for me, "I want you to know that I wrote in your evaluation I would gladly let you care for my family members."

The attending notified the site director for the Internal Medicine clerkship, who offered me space to share what/if I wanted. When we met, she provided me with mental health resources outside of the university. She told me that even if there was truth to the comment, which she did not believe that there was, I was a student and a comment like that would be a reflection and failure of the educator. Then, she asked if she could give me a hug, which I accepted with more tears. Ultimately, I received a glowing evaluation with comments that reflected those from every other core clerkship (aside from the first surgery clerkship) and was offered a letter of recommendation.

Throughout this time, I had been appealing the evaluation and am disappointed to say that my abundance of evidence was not enough against the site director's word. I have included my appeal as a Supplementary file. I was never given a notification or explanation, but the comment "it's a matter of time before she hurts a patient" was removed from my evaluation. The rest of the evaluation and grade were left unchanged and, consequently, I had to repeat the six-week surgery clerkship at a different site. To my knowledge, it does not appear the site director has been or will be held accountable for his dangerous actions.

I needed answers to so many "whys" for acceptance and closure to move on. I met with several leadership members of the university, but each one redirected me to someone else for those answers. Eventually, all deferred the decision, and therefore any answers, back to the surgery clerkship director. I had only met with her once during the appeal process and when I reached out, she did not reply. After emailing her again, her response included "I will not be able to engage in more discussions about this matter" and she pointed me back to someone who had already pointed me to her.

I was terrified to return to the general environment that had almost destroyed my career and future. On the first day of my second surgery clerkship, my intern asked, "What are your goals for this rotation?" My goal was simply to survive, and not talk about my first surgery clerkship experience for six weeks. But being there was so much harder than I thought it was going to be. I made it six hours before I felt it was necessary to tell my chief resident how I was feeling and why. Her response was blunt and validating.

Although being there was a mental and emotional struggle, I did have a great experience. The biggest ghost of my first surgery clerkship was in the Mid-Rotation Student Feedback Form, where a disclaimer had been added: "***This is not a guarantee of your final grade, and it may change pending your future performance on subsequent shifts and your exam.***" It is an understandable statement, but another frustrating response from the surgery department to my experience, as my form from the first surgery clerkship was positive.

Overall, the second surgery clerkship was everything the first surgery clerkship should have been and more. From an attending physician joking with me for "calling out" a chief resident, to a chief resident gladly taking photos of me to capture the memories, and to a resident saying I had a "plastic surgeon's stitch," every interaction was the complete opposite to my first experience. I earned a clinical grade of 93.8% and a High Pass overall, again receiving comments consistent with every other clerkship, aside from the first surgery clerkship.

So What?

Words have value, and too often as medical students, we often feel we become the sum of words like PASS and FAIL, or "it's a matter of time before she hurts a patient." This makes the clinical years of medical school an especially vulnerable time for students, when a large portion of our grade can be arbitrarily decided. A weaponized fail or baseless comment can cause irreparable harm, and such behavior can have devastating consequences. It is not merely jeopardizing a student's career but also their very existence. Suicide rates among medical students are already three times higher than our peers,[9] without the added burden of being targeted by those who should be supporting us on our academic journey.

For this reason, more than any other, we must address the abuse of power dynamics in medical education to protect the well-being and future of every student. Unfortunately, it seems like some individuals in the medical field thrive on abusing power dynamics and see mistreatment as a rite of passage. Who excuse mistreatment as the method to strengthen resilience, because that is how it was done to them. But the desire to have others suffer as you have suffered is pathological. And the defensive nature of constructive criticism does not have a place in the future of medicine.

For decades, mistreatment of medical students has been condemned. But words are easy and often lack the necessary action to support them. My university says students are protected from retaliation, and I would imagine every institution has similar statements. I have unmistakable evidence that retaliation occurred, yet no action has been taken to protect me. It is often hard to prove when personal attacks bleed into professional spaces, but the designated advocate said this was the clearest and strongest case of retaliation they had ever seen. Still, it was not enough. So how are students supposed to feel safe coming forward when they have less or even no proof? When it is verbal, derogatory comments about their background or identity? Or physical, inappropriate moments of touch?

Isolation often serves as shame's closest companion, and that is a break-up I am working on. In the private conversations I have had, and other experiences shared, I know I am not alone in experiencing the pervasive culture of shame in our field. Unfortunately, as medical students, we have little power to do anything. I have been told I should have kept my mouth shut and head down, that the way I have been treated is just how things are. I do not accept that. I am not the kind of person to avoid doing the right thing just because it is the hard thing. And frankly, I would not want my future healthcare providers to do that either.

Moving Forward

What is being done to address medical student mistreatment, and subsequent retaliation for reporting, is not enough. We are still being exposed to negative educational experiences, and those in power to change that are not always supportive. The

burden should not fall to medical students to carve out a space for our own safety, but until the larger system and culture changes, it kind of does.

Over the past year, one of the most important things I have learned is the value of talking to people you trust. As medical students, I think our natural reaction is to keep our struggles to ourselves, likely fueled by imposter syndrome.[10] But it is a matter of time before every medical student faces some challenge during their training. Sharing experiences, advice, and encouragement can cultivate a supportive environment. Continuous, open communication among classmates may also help dismantle the negative effects of the "hidden curriculum" that perpetuate the culture of student mistreatment.

A student-led resource could offer a bottom-up approach to addressing medical student mistreatment by creating a space to facilitate these conversations. However, it is important to acknowledge that the act of sharing personal experiences of mistreatment could add stress to the already stressful experience of being in medical school. Feeling powerless to not only protect ourselves, but also our friends and classmates that we care about, from being mistreated can further add to the emotional burden of the experience. Utilizing this approach would require a strong partnership with and trust in the institution to enact the necessary change to end mistreatment.

Therefore, medical education institutions will always be at the center of change regarding learning environments. While many institutional responses to mistreatment have focused on a top-down approach, there is room for improvement in implementing and executing these policies and procedures. For example, I feel my situation could have been avoided with more proactive and protective policies, especially regarding retaliation. Students, and clerkship departments, should be notified if a student's clerkship performance is not at a passing level before the clerkship ends, to prevent students from being failed only after reporting a concern. Additionally, there should be specific procedures for addressing retaliation, such as involving a third-party to avoid any potential bias. And it is important that there be transparency about how the institution is addressing mistreatment.

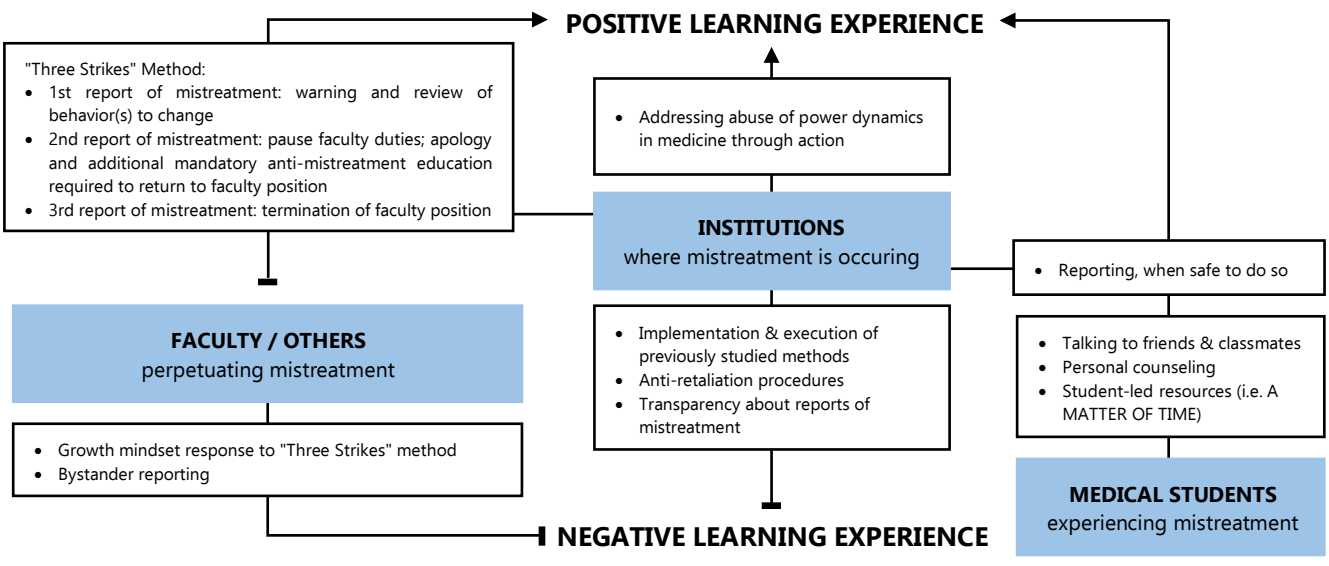
Bottom-up approaches can also be a response within an institution. Bystanders witnessing mistreatment should be encouraged to report. And those reported to be perpetuating mistreatment should be reviewed and held accountable, such as with a "three strikes" method. My suggestions are shown in *Figure 1*.

My hope in sharing my experience is to start a broader conversation about actively addressing the powerless position medical students are in during clinical years and the abuse of power dynamics in medical education. But I am only a fourth-year medical student, I do not have all the answers for the *how* to fix this. And more than anything, I do not have the power to fix this. This needs to be addressed by individuals with that power. I recognize this is complicated to navigate, but the implications are too important to ignore. Condemnation is a start, but it is action that really matters. We all deserve a safe, positive learning environment.

Conclusion

Healing from this experience has been a long process. Sharing this article is part of that conclusion, and it was suggested that I wait for my own well-being. I chose to wait until after re-completing the surgery clerkship and taking Step 2 CK, but I could not wait until after residency matching. I could not carry this alone for another year; I needed to let go to move forward. And I could not continue to play a part in maintaining the culture of mistreatment by staying silent any longer. Publishing this article has been healing for both me and others that have experienced mistreatment during their medical training, and I hope it will protect future students from similar exposures. Based on experiences shared from students, residents, and attendings, my experience could have, and has, happened at other institutions. I

***Figure 1*. Suggestions on How to Encourage More Positive Learning Experiences and Eliminate Medical Student Mistreatment.**



have chosen not to name my university or individuals involved because it is more than an isolated event. Mistreatment happens in many forms across different training sites and specialties and is allowed to occur because of the historic and systemic culture. Part of sharing my experience is to change that culture. I am hopeful that sharing this experience will be seen as a learning and growing opportunity, as I know it has been for me.

The comment "it's a matter of time before she hurts a patient" was truly devastating. Although I know it was written in retaliation and removed from my evaluation, living with that was one of the biggest challenges I had to overcome. I felt it was important to make a broader positive impact out of this negative experience. So, I am developing A MATTER OF TIME, a project intended to support mental health by creating a space for celebration during highs and support during the lows on the journey to physicianhood. As I approach the end of my time in medical school and will soon be focused on the demands of residency, I am hoping to partner with an organization that can help amplify the impact of A MATTER OF TIME. My vision is for it to become a student-led resource in medical schools nationwide to encourage supportive communication among medical students and contribute to a more positive and compassionate generation of physicians.

I did not fail my clerkship, but the clerkship department and university did fail me. And while this experience initially turned my imposter syndrome into a near-invincible beast, I have now slayed it. I know I am a badass medical student and will be an even better physician one day.

I did not choose medical school because it was easy, but it should not be this hard. While I have also had the best time of my life in medical school and thoroughly enjoy being a medical student, I have never felt as powerless as this experience has made me feel and was haunted by it for months. As medical students, we do not have much power. But I have my voice and will not let anyone silence it.

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Supplementary files

Timeline

(As it is not the intended focus, names mentioned in this document have been replaced.)

June 26/27: At the end of the day on June 26, I ran into PA1 and asked him some questions about the next day's schedule. Dr. A had said cases typically start at 7:30 am, but the status board for the next day showed a start time of 7:00 am with Dr. B. As it would be my first day starting in the OR, I wanted to confirm if that was the time the room started getting set up or if that was the time I should be there. He said I would be fine getting there at 7:30 am. The next morning, I showed up around 7:00 am to pre-round on the patient from the previous day before starting cases. I ran into PA2 and told him I would be in with Dr. B's cases that day and would be in the OR at 7:30 am. PA2 said the case was scheduled for 7:00 am and that I absolutely did not want to be late for a case with Dr. B. I hurried down to the OR and made it on time. The previous day, when everyone heard I would be working with Dr. B the next day, they all had some sort of warning. Dr. A had said he would try to intimidate me and I should "just stroke his ego for 5 minutes and all should be good." The morning of his case, when the scrub tech found out it was my first day with Dr. B, they told me to "stand behind [them] and don't say anything." At the time, I had attributed PA1 telling me to arrive late as a misunderstanding, but with all the events that continued to transpire, in hindsight, I believe he was trying to set me up for a bad first impression, especially with Dr. B.

June 27/28: At the end of the day on June 27, I again ran into PA1 and asked him some questions about the next day's schedule. There were overlapping cases with Dr. C and Dr. A on June 28. Dr. A had told PA1 on June 26 that he specifically wanted a PA in his first case as it was going to be difficult. I was under the impression after talking to PA1 the plan was for me to go to Dr. C's first case, while a PA would be in on Dr. A's first case as requested, and then I would go to Dr. A's second/last case. Sitting in Dr. C's case, he was telling the OR how PA1 and PA2 were fighting in the PA lounge that morning about which one would get to come assist with the end of that robotic case because neither wanted to go to Dr. A's breast case. He said they typically take turns and PA1 was in the robotic case the day before, so PA2 thought it should be his turn. However, PA1 was out of town the week prior and missed three of Dr. C's robotic cases, so he felt entitled to make them up this week. Partway through the case, PA1 came in to let Dr. C know he "won" coming to assist him later. He high-fived the nurses and me in celebration before leaving and returning later to close. After the case was over, I received a phone call from PA2, who was angry, saying that Dr. A had been all alone during his first case because they thought I was going to help and they didn't know where I was and that put PA2 in a position to have to go help. He said he was too busy to help with Dr. A's second/last case and was calling to make sure I went. I apologized for the confusion but explained I had understood that Dr. A wanted a PA's help on that case and that I had spoken with PA1 about watching Dr. C's robotic case (and that PA1 saw me in there) and assisting with Dr. A's second case. Because I had heard the backstory from Dr. C in the OR, I felt PA2 was trying to blame me for his not wanting to/not showing up to assist in Dr. A's first case.

July 3: I was working with PA3 and PA4. PA3 brought up how my notes were really not good and how they could never use them to bill as they were. In the Medical Student Expectations from Dr. A and when Dr. A was describing the note expectation during orientation, he specified they should be short SOAP notes, holding up his thumb and index finger which I took as indicating about a paragraph size. I had looked at previous notes from some of the doctors to get a better idea/example and found a recent paragraph size one from Dr. C that I modeled mine after. I tried to explain my understanding of the expectations from Dr. A. She said I was supposed to be doing my notes like theirs, which were longer daily H&P notes, and disregarded my explanation of the expectation from Dr. A. It was confusing and belittling, but I didn't want to argue or seem difficult, so I did H&P notes until after I was told to stop by Dr. A during our July 6 meeting.

July 5: At the clerkship site, I spend two weeks with acute care (I was scheduled for July 3-7 and July 24-28 by Dr. A). During these two weeks, I was expected to round with the on-call doctor and the PAs. This week, it was Dr. E. He rounds in the mornings and again later in the afternoon, but there is no set time that any of the doctors round. On July 5, we finished cases around 12 pm and Dr. E mentioned they would round again around 4 pm. There is a WWAMI study area at the hospital, so I told PA1 I would be going there to study until rounds and that I would be back at 4 pm. I asked if he would text me if they started rounds before 4 pm, he scoffed but said he would. I've noticed a large majority of communication within the hospital is texting, so I didn't think it was an unreasonable request but he made me feel that coming from me it was. He did text me around 3:30 pm telling me rounds were at 4 pm.

July 6: I knew all three PAs were working that day. Typically, I work on one of the computers in the PA lounge, which works out because that is where they/the doctors meet prior to rounds. However, there are only 3 computers in the lounge, so when all three are working, I have to go find a computer elsewhere. I ran into PA3 in the locker room and told her I would be at a different location to do my notes that morning and asked if she could text me when they start rounds. Again, there is no set time rounds begin. She proceeded to lecture me about how "we" can't be responsible for texting me all the time. I needed to be "independent" in figuring things out for myself and being where I needed to be and when. She said it was my responsibility to just keep checking in the lounge to see if they were there or not (which Dr. A during our meeting later that day told me not to do). Again I've noticed a large majority of communication within the hospital is texting, so I didn't feel it was an unreasonable request. Logging in and out of Epic while trying to complete the longer H&Ps every 5 minutes didn't seem logical. I felt I had been independent in completing my responsibilities,

there were just two special circumstances I was asking for help. But what shocked me the most was her use of "we." PA1 had been the only PA in the lounge the previous day, so I now knew they were complaining to each other about me. Dr. E was the previous site director, so when it was just us scrubbing in later that day, I asked if I could speak with him about some of my concerns since I would not see Dr. A for about a week. I said I felt there was growing tension with the PAs and wanted a better understanding of what our interactions were supposed to be in hopes of deescalating. He said he would have time to discuss it the next day.

- During the last case, Dr. E came in with PA1 and he was surprised to see me in there. He thought I would be in the case with Dr. B and Dr. G. Dr. G is a vascular surgeon who only comes once a month. In the Medical Student Expectations from Dr. A, it says to prioritize attending cases with Dr. G. But it also says to complete any acute care surgeries before scrubbing in for elective surgeries. I hadn't considered that I would be assigned to acute care when Dr. G was in town, so that was my mistake for it not to be on my radar. More on this during my meeting with Dr. A later that day.
- At the end of the case, Dr. E left me to close with PA1. I was doing a running subcutaneous stitch and hadn't buried my knot yet (so I hadn't yet checked the integrity of my stitch) before PA1 started pulling on the stitch and announcing that I had left a hole. He kept going on announcing the hole, saying he didn't know what I had done, asking if I could see the hole, saying he needed more suture to fix my mistake, etc. I acknowledged my mistake, but I didn't want to make excuses (though didn't feel I was given an opportunity to catch/correct my mistake) and was feeling publicly humiliated, so my responses to his comments were minimal. When he continued to carry on, the anesthesiologist peeked over the drape to step in, saying he remembered what it was like trying to suture as a medical student and was trying to be encouraging, telling me that I was doing my best. I was moved by his thoughtfulness and it did make me teary-eyed.
- As I was leaving, I ran into Dr. E who said he ran into Dr. A who wanted to chat with me. I assumed he had mentioned my request earlier to discuss the PA tension, so I went to Dr. A's office and after telling him my concerns, he said he wasn't aware and that he just wanted to do a 2-week mark check-in. He did say it technically wasn't their responsibility to be texting me for rounds, but it wasn't an inappropriate request and that I probably would have irritated them by popping my head in every 5 minutes. I told him I understood they were small, negative interactions, but my main concern was that it was escalating. That morning, I had learned they were talking poorly about me amongst themselves, and by the end of the day it was public humiliation in the OR to the point another doctor stepped in to defend me. I wasn't sure how evaluations were completed for this rotation, as most of my time was spent not with the doctors, but with their PAs. And if they were speaking poorly of me amongst themselves, I expected they would do the same with the doctors. I worried about how it would affect my experience and evaluation. Dr. A said they do typically rely on the PAs for feedback and tried to consider potential reasons for the tension:
    - He said the PAs are compensated for their involvement in teaching medical students, saying as the site director he gets twice as much as the other doctors and the PAs get half as much as the doctors (this conflicted with what he told me on my last day). He also mentioned they teach PA students, so maybe there was some role confusion.
    - I hadn't specifically mentioned any PA by name, but Dr. A asked if it was mostly PA1. He said there have been some issues with him in the past, but he just tries to take a "father-like" approach with the students that sometimes comes off the wrong way. That portrayal/mindset from Dr. A and PA1 made me uncomfortable and I felt it was not appropriate for a workplace or learning environment.
    - He asked if they knew I wanted to go into pediatric psychiatry, and when I said yes alluded that maybe they weren't taking me seriously because of that interest. I have been very clear on all my rotations when asked what specialty I'm interested in, that while I am pretty set on pediatric psychiatry, I am keeping an open mind. And at the very least, if I chose pediatric psychiatry, I will never do anything like this again so I want to make the most of my experience.
- We then shifted to more of a two-week check-in conversation. He looked at my notes and said they were good, however very long and detailed, more on the scale with expectations of a PA or PA student, and would take too much time for a medical student to do, as most of my time was supposed to be spent in the OR. He told me to return to doing a shorter SOAP note and shared his template with me. (I know the PAs read my notes, so I believe returning to shorter notes after they specifically told me to write longer ones contributed to the continued tension). On the topic of short notes, he shared that he dislikes how short Dr. B's notes are and it is hard to know what's going on when he takes over his patients. He said sometimes Dr. Bd's notes are also quite inappropriate, like saying the patient received a "pornstar" shave prior to the surgery. Dr. B and Dr. D have to be in separate clinic spaces/floors because of personal dramas. Dr. A made a comment that he doesn't like drama and I apologized for the drama with the PAs and he just brushed it off as not a big deal.
- With regards to missing Dr. G's case, Dr. A did say the PAs are supposed to be letting me know about his cases and other more interesting/unique opportunity cases, which they did not. (I also later went and looked at the Epic status board for Dr. G and it just had Dr. B's listed, so I am unsure how I could have known on my own that Dr. G was in town/assisting him.) He would not be back during my clerkship, so I was disappointed to miss out on that opportunity, likely due to this tension.
- Dr. A kept saying how medical students usually get along so well with the PAs. The conclusion of the meeting was to continue sticking close to the PAs, but if tension continued to just come and work in his clinic.

July 10: There were no scheduled elective surgeries that day, so when checking in with the PAs that morning, I told PA3 I would scrub in for Dr. F's (the on-call doctor) acute care case. When Dr. F and PA2 arrived in the OR, PA2 announced from the other side of the OR (in front of Dr. F, the nurses, the scrub tech, and the anesthesiologist) that I had skipped rounds that morning. I responded that I only round when I am on acute care, which was the previous week, to which he responded that I had missed 18 acute care patients that morning. I felt humiliated being accused of something I hadn't done, but didn't feel it was appropriate to argue about it across the OR room, so I went to scrub in. When PA2 came to scrub in as well, I explained to him again I was not assigned to acute care that week. Dr. F was present for the OR situation and would have been the rounding physician that morning, and I believe the PAs' portrayal of me was a direct cause of my interaction with Dr. F on July 25.

July 11: Still feeling the escalating tensions with the PAs and the new and continuing public humiliation attempts, I thought it was best to speak directly and privately. The morning after the incident in the OR with PA2, I asked if I could speak with him in the hallway. I told him I was on the clerkship for my education first and foremost and I would not intentionally skip opportunities. I understood there was some confusion the day prior, but asked that if he had any concerns about my performance moving forward that he come to me directly. Initially, he seemed receptive and understood where I was coming from. But suddenly, he flipped and said he "was upset now," that he had "never been called out by a student before." He asked, "Do you want me to just ignore your existence because I can do that." I felt like he was attempting to gaslight me about how the experience made me feel, but I didn't want to escalate the conversation anymore. So I just let him continue on and eventually, he calmed down. He said I was welcome to be joining them on rounds outside of my acute care weeks. I said it was tricky because they don't round at set times, to which he responded to just text about it. I was almost speechless since PA1 and PA3 have been so adamant about *not* texting for rounds.

- In between the two cases for the day, PA1 told me Dr. A wanted to speak with me and that I should go now. I went looking for Dr. A, and his office said he may have left for the day. I text him and he told me to call him that night. Since I was supposed to be in his cases the next day, I figured it had to do with my conversation with PA2 if it couldn't wait until the next day. When I called, I explained what happened with PA2 and he said that is about what Dr. B told him happened. I was a little confused about how Dr. B became a part of this but again wondered if the PAs were trying to get me on his bad side, especially due to his reputation. Dr. A said it is a dynamic rotation, switching back and forth between acute and elective care and when there isn't much going on, I am welcome to round with the team. He said he wasn't sure how "we" got off on the wrong foot with the PAs (which I did appreciate the use of "we"), but that he wasn't stressed about it and didn't want me to be stressed about it either. The resolution was for me to limit my interactions with the PAs. I no longer checked in with them in the morning or rounded. Dr. A would send me the cases to scrub into each week. Dr. A said they typically don't have medical students in the clinic, as it slows them down, but he did invite me to spend a couple of days there during the remainder of my rotation. Dr. C also invited me to his clinic once.

July 17: A small thing, but just another example of the constant contradictions between the PA's expectations and the expectations from Dr. A. I was working on my notes at a computer not in the PA lounge when I saw PA1. He told me PA2 said I was supposed to be signing my notes with a note about the attending I discussed them with. In the Medical Student Expectations document, with regards to giving the attendings a report on a patient, Dr. A says "It's great if you can find us don't waste time trying to track us down because we can be elusive!" I rarely saw the doctors outside of the OR, so I did not get many opportunities to present patients. There was also nothing in the Medical Student Expectations document about signing notes with "discussed with."

July 21: Since July 11, I saw the PAs less frequently. However, I never knew who/where/when I would be interacting with them again, which led to a lot of anxiety. When they were around, there was definitely tension that everyone seemed to ignore so I also tried to follow that lead. On July 21, I was left to close with PA3. I have watched the PAs close with the doctors dozens of times, and they have a rhythm assisting with dabbing oozing wounds when the doctor pulls a stitch through, cutting suture, etc. PA3 was watching me suture, holding the only Raytec in the field in her hand. I pulled a suture through and the wound was oozing, so I held the needle driver out of the way and asked PA3 if she would dab. I don't have the same rhythm with the PAs as the doctors do, so I try to be more verbal to avoid any accidental needle pokes. PA3 snapped that I should be "independent" and doing things on my own. I explained why I had asked her and then asked the scrub tech for another Raytec and finished independently. I believe surgery is arguably one of the most *inter*dependent specialties and that it is dangerous to have that mindset in the OR. As students, we are still learning and this continued narrative from PA3 could have been handled in a more helpful way.

- I closed with PA2 alone later, probably the first and only interaction I had with him since July 11 and for the remainder of the rotation. Without asking, he was very helpful while I closed and treated me in a professional and respectful manner.

July 25: I was supposed to be on acute care again this week (July 24-28), but Dr. A just had me do rounds with him on July 24 when he was covering for Dr. F and then participate in elective cases for the rest of the week. There were no scheduled elective cases for July 25, so when Dr. A asked me what my plan for the day was I told him I would text Dr. F in the morning to let him know I was on call, to which he agreed was a good idea (call requirements for the clerkships were one day a week and two weekends). When I text Dr. F on July 25, his response was "Take me off this list". I worry that is a direct result of what occurred on July 10.

July 27: I was left with PA1 alone to close. When the scrub tech was getting me a needle ready, PA1 told him he didn't want me to close. It was a robotic case, so I had only been watching for the rest of the surgery. When I saw Dr. A later, he asked how watching "robo-tv" and closing had gone. I told him PA1 didn't want me to close, and he didn't have a reply.

Aug 2: This was my last day and even though I had a poor experience, I still was appreciative of the opportunity. I have baked cookies to bring in with thank-you notes on my previous rotations and treated this one no differently. Dr. A thanked me for the cookies and mentioned how it was a nice gesture, as all the faculty are volunteers, and he was the only one that received a little compensation for having students as the site director (this conflicted with what he said during our meeting on July 6). We had a brief goodbye. I text him that I would be leaving that evening for a positive environment to finish studying for and to take this shelf exam. I offered to chat the next day about my clerkship experience, hoping for some follow-up/final clerkship feedback. He declined and his response included: "After a bit of a rough start to the rotation you finished strong." I also text PA2, saying "I know we have had our tensions during this clerkship, but I wanted to let you know I appreciate the way you have treated me during our last few interactions". His responses included "Don't think of it as tension, but rather confusion about roles and expectations."

Appeal

(As it is not the intended focus, names mentioned in this document have been replaced and location removed.)

I am disputing the clinical fail and evaluation I received on my surgery clerkship from June 26, 2023 to August 4, 2023. I believe the evaluation is the result of retaliation for sharing I would be voicing concerns about the site. There are also significant irregularities in the grading process of my evaluation.

Summary of Retaliation

Throughout my surgery clerkship, there was tension with the physician assistants (PAs), who were also referred to as Advanced Practice Clinicians (APCs). The tension started as small slights and eventually escalated to public humiliations. I spoke about this with Dr. A, the site director, on two separate occasions and he made changes to decrease their opportunities to interact with me. However, the interactions did not stop entirely and neither did the tension. Still, I was able to complete the clerkship.

Based on the written feedback I received during and directly after the clerkship, there were no concerns about my performance. On July 18, two weeks and one day before my last day, my Mid-Rotation Student Feedback Form was completed by Dr. A where he selected "meets expectations" for every category (Exhibit A - Mid-Rotation Feedback). On August 2, my last day of the clerkship, I offered to discuss my clerkship experience with Dr. A, hoping for some follow-up about the PA environment. Dr. A did not accept, but stated, "After a bit of a rough start to the rotation you finished strong" (Exhibit B - Dr. A Text). On August 4, two days later, I received a voicemail from Dr. A, where he said individuals I worked with shared they were "unfortunately, not overly impressed with [my] performance and just thought [my] knowledge base in the operating room wasn't super," but he was still waiting on feedback from Dr. E, the previous site director. Dr. A went on to add, "I thought you kinda got it together and finished at least okay" (Exhibit C - Dr. A Voicemail). At no point of feedback was there mention of concerns I was failing the clerkship.

As it was after hours, I responded to Dr. A's voicemail by email (Reference 1 - Voicemail Response Emails). I addressed his comments and shared that I had hoped for more discussion about my clerkship experience and the continued poor interactions with the PAs. I informed him I had been keeping a timeline of events that occurred during the clerkship and would be completing my evaluation of this experience. I had started the timeline in hopes I would have an opportunity to collectively discuss the experience with Dr. A at the end of the clerkship. On August 6, I submitted my evaluations, including the timeline, which I also sent directly to the Learning Environment department. The content of the timeline isn't relevant to this dispute, but for completion, it is attached as Reference 2 - Timeline. The events that followed informing Dr. A of the timeline highlight a shift from what appeared to be a successful completion of the clerkship to a failing grade, with serious allegations raised against me.

On August 7, I was discussing my concerns over the phone with Z, Director of the Learning Environment, when I received an email from Dr. X. The email was regarding a photo in an operating room that I had posted on Instagram from my OBGYN clerkship in Anchorage, AK. More information is included below in Additional Information. Dr. A was cc'd. Z advised sending a short reply simply stating no policy violation had occurred, and I did "reply all" with my response. Later that afternoon, I received a reply to the same email thread from Dr. A. However, it was addressed to Dr. X and I was the only recipient, suggesting Dr. A clicked "reply" to the conversation thread with the intent to respond to Dr. X, but instead responded to the most recent sender in the email thread, me (Exhibit D - Dr. X Emails). Notable comments in his email include: "Sierra was quick to tell me that she would also be giving me a poor evaluation as well....." and "she will be receiving a poor or failing grade from us." I shared this with Z, who stated this email thread warranted immediate escalation of this situation for Dr. Y, Surgery Clerkship Director. I agreed and gave my permission for her to do so.

On August 10, I received an email from Dr. Y with the failing grade and evaluation she had received from Dr. A (Reference 3A - Evaluation Email). For completion, I have addressed these comments point-by-point in Reference 3B - Evaluation Comments, but for conciseness, I will address the most pertinent to his retaliation in this dispute. Dr. A wrote an unnamed individual shared the following about me: "Failed on a personal and professional level. It's a matter of time before she hurts a patient and then what do we say? We are not liable if we tell the truth." This is a very serious concern that was never brought to my attention prior to receiving my evaluation. Nor had Dr. Y or the university been made aware of any concerns during my clerkship, or Dr. A it seems. If this were a valid concern, any one of them should have been notified immediately. And if it were a valid concern, my interaction with patients should have been adjusted, paused, or stopped immediately. Yet, on July 31, just two days before my last day, Dr. C, a surgeon at the site, directed me to drive the robot alone to suture the peritoneum after an inguinal hernia repair and then said I had done well. These concerns about patient safety were only made after I stated I was going to be sharing my experience with the university.

In conclusion, I feel my failed clinical grade and evaluation comments were due to retaliation as described above. I recognize that I did not excel on this clerkship due to the site not promoting a positive learning environment; however, I believe I was at least at a pass level according to Dr. A's comments throughout and immediately after my clerkship, with feedback such as "meets expectations," "at least okay," and "finished strong." Concerns about my performance and patient safety were only raised after I shared I would be completing my evaluation of the clerkship experience. This is supported by the attached mid-rotation feedback, text, voicemail, and, most importantly, the email accidentally sent to me where Dr. A shared I was going to give a negative evaluation and that he was going to give me a failing grade. There were also irregularities in the grading process, as described below.

Summary of Irregularities in the Grading Process

On August 29, I received an email from Dr. Y with her decision on the grade review/challenge and a summary of her conversation with Dr. A (Reference 4A - Grade Review Email). For completion, I have addressed these comments point-by-point in Reference 4B - Grade Review Comments, but for conciseness, I will address the most pertinent to the irregularities in this dispute. Several significant irregularities in the grading process are noted below, and the two I feel are most important to note are:

- The evaluation comment above ("Failed on a personal and professional level. It's a matter of time before she hurts a patient and then what do we say? We are not liable if we tell the truth.") was removed from my evaluation by Dr. Y. In my grade review meeting with Dr. Y, I expressed my distress about that specific comment, asking if she could get further insight from Dr. A. I have received no further clarification about the nature of the comment, but Dr. Y did not include it in my posted evaluation (Exhibit E - Surgery Evaluation). I do not believe the university would remove such a serious concern if they did not feel justified in doing so, pointing to the invalidity of the comment. I believe having to remove any part of the evaluation decreases the credibility of the evaluation as a whole.
- I feel both the student and clerkship department should not be surprised when a student fails a clerkship, especially if there are significant alleged patient safety concerns. I was not made aware of any concerns throughout or even directly after finishing the clerkship and was only notified I would fail in the email accidentally received on August 7. The surgery clerkship department was not made aware of any concerns regarding my performance or patient safety at any time during my clerkship.

Additional comments of significant note are included below:

- In his meeting with Dr. Y, Dr. A shared his Medical Student Surgery Clerkship Expectations document, stating I "did not utilize or pay attention to this information." Dr. Y shared the document with me, and it is not the same one I was provided by Dr. A prior to this clerkship. Exhibit F1 - Expectations is the document I received on June 22 and Exhibit F2 - Expectations is what Dr. Y received from Dr. A, with changes and additions marked and noted. In the document sent to Dr. Y, there are several changes and additions that seem to be directly related to my experience, particularly additional notes about the PAs.
- When Dr. Y questioned Dr. A about mid-rotation feedback (Exhibit A - Mid-Rotation Feedback) and the text he sent on my last day (Exhibit B - Dr. A Text), he argued two conflicting narratives about the sudden failure of my clerkship:
    - With regards to the mid-rotation feedback, he stated my performance "fell apart the last 3 weeks of the clerkship." If my performance had shifted so drastically and had been falling apart during the last 3 weeks of the clerkship (from July 12- August 2), it would have made sense that he noted it in the mid-rotation feedback form completed July 18; but, he did not. It also would have made sense that he bring the concerns about my performance to me, Dr. Y, and/or the university; but, he did not. If he thought my performance was deteriorating over the last three weeks, it would not have made sense for him to text that I had "finished strong" on my last day (August 2); but, he did.
    - With regards to the text he sent on my last day, he stated that it was sent before he received feedback from other individuals I worked with, shifting the reason for the sudden failure after the clerkship to other's feedback. However, I spent roughly as much time with Dr. A as I did with all the other surgeons combined. The approximate breakdown of the days spent with the surgeons from July 17-August 2 is: Dr. A: 7 days, Dr. B: 2.5 days, Dr. C: 2 days, Dr. D: 2 days, and Dr. E: 0.5 days (Reference 5 - Schedules). Therefore, his opinion that I had finished strong

on my last day should have held the most weight. Additionally, he was only waiting on Dr. E's feedback to finish my evaluation when he left the voicemail where no comments about failing or concerns about patient safety were made.

- Based on my relationship and tension with the PAs and the severity of some of the evaluation comments, I worried about their role in my evaluation. Dr. Y discussed this concern with Dr. A during their meeting, she said "he stated it was the surgeons not the APCs who provided feedback by the way." However, in his evaluation, he wrote at the beginning and end of that it was based on his conversations with his partners and the APCs, which included the PAs (Exhibit E - Surgery Evaluation).

In conclusion, there is an overwhelming amount of contradictions, inconsistencies, and irregularities regarding this clerkship and evaluation. For clarity and conciseness, I have included the ones I believe to be most pertinent, though many other ones are addressed in the attachments. Any one of these seems to make my overall final grade and evaluation unreliable.

Additional Information

Disinterest in a Surgical Specialty: My desired future in medicine does not include a surgical specialty, something that was brought up several times in my evaluation. I started medical school with an interest in pediatric psychiatry and have answered honestly about my intentions when asked. It has led other attendings to guide my experience to include opportunities related to my interest when they arise. I was asked several times during my first week what specialty I wanted to go into and believe the individuals at this surgery site came to certain conclusions about me because of my career interest. When discussing the PA tensions with Dr. A on July 6, he even postulated that was a potential cause for their behavior. Level of interest in a specialty is not the same as performance during a clerkship, which I believe I have made evident with my performance during my other clerkships, and interest should not be factored into the evaluation process. I have completed my OBGYN and family medicine clerkships, also specialties I am not interested in, but approached those clerkships the same way I did surgery: with an open mind and knowing, at the very least if I chose pediatric psychiatry, I would never do anything like this again and wanted to make the most of my experience. If I truly did not give clerkships I was not interested in pursuing a career in the serious effort they deserved, I would have done poorly on my other clerkships. Yet, even though OBGYN and family medicine were not specialties I was interested in, I had a great experience on the clerkships, learned a lot, and received very positive evaluations (see below) and clinical high passes.

- OBGYN Evaluation (Reference 6 - OBGYN Evaluation): "Sierra was an integral part of our medical team while on service. She was very compassionate and empathetic with patients. She took the time and extra effort to get to know our patients in labor and our patients knew her name and she was an active participant in the delivery. Sierra is on her way to becoming an amazing physician. She has the qualities you can not teach and she is works hard studying and learning all that she can. I have no doubt Sierra will be extremely successful in her career in medicine."
    - Additionally, I completed this clerkship on May 3. On August 8, several months later, W, a student I had met in Bozeman, started her OBGYN clerkship with one of my OBGYN attendings. I told her to tell the clinic doctors "hi" and she shared the resulting text: "They LOVED you and said to say hello back! I feel like I got brownie points for being your friend." (Reference 7 - W Text)
- Family Medicine Evaluation (Reference 8 - Family Medicine Evaluation): "Student Doctor Norman progressed through this family medicine rotation so that she was able to present oral and written cases in a consistently logical and organized manner especially with problems that became more familiar to her. She usually developed reasonable diagnostic plans reflecting appropriate clinical reasoning. She became comfortable performing common office procedural skills. Her patient centered communication skills really highlighted her strengths of emotional intelligence, discovering and guiding patients where their mental health needs affected their physical condition and suggesting practical ways to navigate those problems. She consistently sought evidence based management of her patients and read consistently to improve her knowledge base, showing great growths in this during the rotation. She was always professional in interactions with patients and staff and responsive to feedback."

Instagram Photo: Dr. Y has reviewed the concern and confirmed no HIPAA violation occurred. The photo in question was taken by an attending in Anchorage, AK during my OBGYN clerkship and posted on May 27, a month before I started my surgery clerkship in Bozeman, MT (Reference 9 - Instagram Post). I enjoy being a medical student and like taking pictures to commemorate this experience, but absolutely make sure it is done appropriately and respectfully. I feel it has been strongly suggested that the university likes us to capture these moments. When sending thank you notes to scholarship donors, there is a place to upload photos to let them know what we are up to. Also, the university Instagram page had requested to repost my OBGYN clerkship photo, and just the other day I received another request for additional photos to be shared by the university Instagram.

Surgery Shelf Exam Fail: I recognize I am not the strongest test taker, as evident by my previous shelf exams, earning a 62 with a passing threshold of 62 on my OBGYN shelf and a 68 with a passing threshold of 58 on my family medicine shelf (Reference 7 - OBGYN Evaluation and Reference 8 - Family Medicine Evaluation). External events do take an emotional toll on my exam performance. During my OBGYN clerkship, my grandmother passed away. When my surgery clerkship ended on August 2, I had to make a decision

on study quality vs quantity with my remaining time. Maybe quality was the wrong decision and I fully accept having to redo the surgery shelf exam. I missed passing by two questions, so I know with time to heal from this distressing experience, I will be able to pass the surgery shelf exam.

Additional Notes of Concern: This whole situation has been very distressing, but the accusation about hurting a patient in particular was the most distressing of it all. It has haunted me as a student and future caregiver and could seriously, negatively impact my career progression. In addition to the concerns included in this dispute, I have provided information regarding the environment of this site and my experience with the Learning Environment department, included for completeness (Reference 10 - Additional Notes of Concern).