Toronto Academic Health Science Network

Responding to Learner Mistreatment from Patients, Family Members and Visitors

Faculty/Supervisor and Learner Guide

PURPOSE

Toronto Academic Health Science Network (TAHSN) exists as a dynamic consortium of the University of Toronto and its affiliated academic hospitals to serve as a leader in Canadian health care. This is done through developing collaborative initiatives that optimize, advance and sustain high-quality patient care, education, knowledge transfer and research innovation. Specifically, TAHSN's Education Committee (TAHSNe) commits to supporting and developing a TAHSN-wide strategy to further excellence in health professional education. A key TAHSNe priority is to address learner mistreatment.

Responding to Learner Mistreatment from Patients, Family Members and Visitors: Faculty/Supervisor and Learner Guide was created by TAHSNe's Learner Mistreatment by Patients & Families Working Group and approved by TAHSNe. The information in this guide is intended for supervisors to leverage and share with learners, so they can create an environment where learners feel safe and supported when mistreatment occurs.

This resource guides both faculty/supervisors and learners (who participate in clinical placement) at the TAHSN hospitals on ***how to respond to*** and ***debrief an incident of mistreatment*** that they have experienced with a patient, a patient's family member or a visitor. It describes various forms of learner mistreatment by patients, their families and visitors; outlines foundational requirements of learner safety; offers guiding principles and recommendations for how faculty/supervisors can support learners once mistreatment has occurred; and discusses strategies that learners can use to intervene safely when they experience or observe any form of mistreatment.

OBJECTIVES OF THIS GUIDE

- Define the multiple forms of mistreatment that learners may encounter.
- Describe policies and legislation that support learners' rights.
- Provide learners with a decision-making framework, preventative approaches and safe-intervention strategies for navigating and addressing incidents of mistreatment.
- Provide faculty/supervisors with strategies and resources they can use to support learners who experience mistreatment from patients, families or visitors.
- Identify procedures and steps that both learners and faculty/supervisors can use in debriefing following incidents of learner mistreatment.
- Highlight the importance of self-care and introduce strategies, resources and considerations for promoting personal wellness when mistreatment occurs.

ACKNOWLEDGMENTS

A special thanks and acknowledgment to the following people for developing and approving this guide:

Learner Mistreatment by Patients/Families Working Group (LMP)

Sanjeev Sockalingam, LMP Co-lead, Vice President, Education, Centre for Addiction and Mental Health

Golda Milo-Manson, LMP Co-Lead, Vice President, Medicine & Academic Affairs, Holland Bloorview Kids Rehabilitation Hospital

Arno Kumagai, Vice Chair, Education, University of Toronto

Erin LeDrew, Manager, TIDES and Community Education, Centre for Addiction and Mental Health

Emmanuel Bratsalis, Community Health and Education Specialist, Centre for Addiction and Mental Health

Kathryn Parker, Senior Director, Teaching & Learning Institute, Holland Bloorview Kids Rehabilitation Hospital

Katie Hodgson, Education Specialist, Centre for Addiction and Mental Health

Linda Slodan, Manager, Interprofessional Education, Centre for Addiction and Mental Health

Leora Branfield Day, Chief Medical Resident, University of Toronto

Pier Bryden, Senior Advisor, Clinical Affairs & Professional Values, Temerty Faculty of Medicine, University of Toronto

Reena Pattani, Director of Learner Experience, Temerty Faculty of Medicine, University of Toronto

Stacy De Souza, Education Specialist, Centre for Addiction and Mental Health

Stephanie Sliekers, Manager, Simulation & Digital Innovation, Centre for Addiction and Mental Health

Tarek Abdelhelim, Assistant Professor, Temerty Faculty of Medicine, University of Toronto

Hillary Chan, Advisor, Toronto Academic Health Science Network, University of Toronto

Adrienne Fung, Advisor, Toronto Academic Health Science Network, University of Toronto

Laura Hayos, Education Development Lead, Clinical Teaching and Operations, Centre for Faculty Development

Tucker Gordon, Community Health and Education Specialist, Centre for Addiction and Mental Health

Joanna Zygmunt, TIDES Specialist, Centre for Addiction and Mental Health

Latika Nirula, Director, Centre for Faculty Development

TAHSN Education Committee

Ari Zaretsky, TAHSNe Co-chair, Vice President of Education, Sunnybrook Health Sciences Centre

Patricia Houston, TAHSNe Co-chair, Acting Dean, Temerty Faculty of Medicine, University of Toronto

Alison Freeland, Vice President, Education, Academic Affairs and Patient Experience, Trillium Health Partners

Beverly Bulmer, Vice President Education, Unity Health Toronto

David Conn, Vice President Education, Baycrest Hospital

Derek Hutchinson, Director, Professional Practice, Education, and Research, Humber River Hospital

Donna McRitchie, Vice President, Medical and Academic Affairs, North York General Hospital

Golda Milo-Manson, Vice President, Medicine & Academic Affairs, Holland Bloorview Kids Rehabilitation Hospital

Jacqueline James, Vice President, Education, Sinai Health Systems

Jennifer Yoon, Senior Director, Professional Practice, Quality and Patient Safety, Humber River Hospital

Linda Johnston, Dean, Lawrence S. Bloomberg Faculty of Nursing, University of Toronto

Lindsay Martinek, Director, Professional Practice, Renal, Oncology, Nursing Resource Team & Academic Partnerships, Michael Garron Hospital

Mandy Lowe, Senior Director, Clinical Education, University Health Network

Pam Hubley, Vice President of Education and Academic Practice & Chief of International Nursing, Hospital for Sick Children

Peter Tzakas, Chief of Medicine, Michael Garron Hospital

Rulan Parekh, Vice President Academics, Women's College Hospital

Sacha Bhinder, Co-chair Medical Education Committee, Scarborough Health Network

Theresa Kay, Director of Education, Women's College Hospital

Sanjeev Sockalingam, Vice President, Education, Centre for Addiction and Mental Health

Heather McPherson, President and Chief Executive Officer, Women's College Hospital

Hillary Chan, Advisor, Toronto Academic Health Science Network, University of Toronto

Adrienne Fung, Advisor, Toronto Academic Health Science Network, University of Toronto

We also thank TASHNe's Learner Experience Advisory Group for reviewing this work.

A special thank you to Hannah Samuels, Resident in the Department of Psychiatry, University of Toronto, and Kishan Baskaran, Master of Social Work Program, York University.

CONTENTS

INTRODUCTION

Learner mistreatment by patients and families remains a persistent issue, with verbal harassment being the most common form of abuse (Whitgob et al., 2016). Although the phenomenon of learner mistreatment has been recognized since the 1980s, it is now garnering more attention as efforts are increasing to address patient conduct that is racist, sexist or discriminatory (Warsame & Hayes, 2019; Whitgob et al., 2016). For learners, the implications of experiencing mistreatment vary, but two serious consequences are posttraumatic stress and decreased interest in pursuing a career in medicine (Haviland et al., 2011; Heru et al., 2009; Zhu et al., 2019).

Unfortunately, even with such impactful consequences, many learners accept mistreatment as an unavoidable part of the socialization process. They do not report incidents or address them directly because they require reliable and standardized guidance, fear repercussions or believe that no action will be taken if they report them (Smith-Coggins et al., 2017).

KEY PRINCIPLES

When a learner is mistreated by a patient or the patient's family, the process of responding to, managing and debriefing about the incident relies on three key principles: ensuring learner safety, using a trauma-informed lens and supporting learner growth (Figure 1).

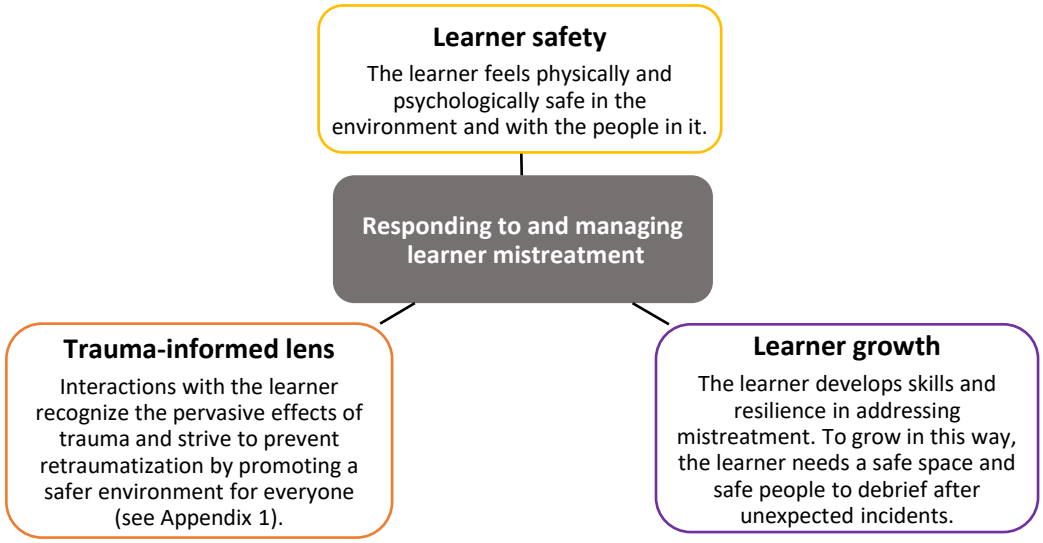

Figure 1. Key principles of responding to learner mistreatment

CATEGORIES OF MISTREATMENT

This section examines various forms of mistreatment (North York General Hospital, 2021). Within the context of health care professions education, mistreatment refers to intentional or unintentional behaviour that shows disrespect for the dignity of others and interferes with the learning process.

Mistreatment may involve:

- a single incident or a pattern of behaviour that ranges from subtle gestures and/or comments to egregious actions
- any behaviour that involves mistreating another person and that compromises the learning environment
- microaggressions that may be unintentional, but that are experienced as a pattern of snubs, slights, put-downs and gestures that demean or humiliate people based on their belonging to a group, particularly those identified by gender, race/ethnicity, sexual orientation, immigration status or socioeconomic class.

Mistreatment results from any of these behaviours:

- unprofessional behaviour
- discrimination and discriminatory harassment
- sexual violence and sexual harassment.

Behaviours that fall under the categories of discrimination and discriminatory harassment or sexual violence and sexual harassment are considered unprofessional. However, we present them as discrete mistreatment categories because they are defined and addressed through specific hospital policies, as well as in the Ontario Human Rights Code. The examples below are not exhaustive and are not intended to represent the spectrum of behaviours that may be considered mistreatment.

Unprofessional behaviour includes being:

- required to perform personal services
- publicly humiliated, implicitly (e.g., eye-rolling) or explicitly
- subjected to recurring outbursts of anger (e.g., shouting, throwing objects)
- subjected to disparaging remarks about the character or patient care of another physician/health professional/learner
- inhibited by a person in authority from providing appropriate feedback/evaluation, including disclosures or reports of mistreatment
- subjected to retaliation in response to a disclosure, report or investigation of mistreatment
- threatened with physical harm
- physically harmed
- faced with issues related to academic integrity or research integrity.

Discrimination and discriminatory harassment involve being:

- subjected to offensive remarks/names related to or based on race, ethnicity, gender, sexual orientation, religion or any of the other protected grounds identified in the Ontario Human Rights Code
- denied opportunities for training or rewards based on any of the protected grounds identified in the Ontario Human Rights Code
- given lower evaluations/grades based on any of the protected grounds identified in the Ontario Human Rights Code
- denied academic accommodations or subjected to critical, dismissive or demeaning remarks about approved accommodations (e.g., time to perform a smudging ceremony, pray, commemorate religious observance)
- denied reasonable academic accommodations based on disability.

Sexual violence and sexual harassment involve being:

- subjected to sexist remarks/names
- subjected to sex-related comments about one's or someone else's physical appearance or actions
- subjected to unwanted sexual advances
- asked to exchange sexual favours for grades or other rewards
- inhibited by a person in authority from reporting unwelcome sexual comments or unwanted sexual advances.

NOTE: The above forms of harassment and discrimination are often linked. This phenomenon is called intersectionality and denotes that racism, discrimination, harassment and vilification are frequently shaped or informed by other elements such as sex, gender and sexuality. For descriptions of harassment, discrimination, racism, microaggressions and related concepts, see the glossary.

FOUNDATIONAL REQUIREMENTS FOR ADDRESSING MISTREATMENT

One of foundational requirements for supporting learners who have experienced mistreatment is to establish an environment where learners feel psychologically safe. **Psychological safety** means promoting a culture of openness and respect for everyone, regardless of their social location or position. It also means championing spaces that are brave (Ali, 2017; Cook-Sather, 2016; Wheeler et al., 2019; Wiesenfeld, n.d.).

Faculty/supervisors must acknowledge the power imbalance that exists in clinical settings and recognize that it may make some learners reluctant to share their experiences of mistreatment with them or other senior members of the team (Wheeler et al., 2019). Learners may not feel the mistreatment was significant enough, they may be concerned about making the situation worse and are worried about consequences, or they may not know how to handle the situation.

Learners reported feeling scared, humiliated, sad and angry after experiencing some forms of mistreatment (Zhu & Tan, 2019).

Many faculty/supervisors may not be aware of the power and control they have in setting the expectations for learners and the tone of the learning environment (Wheeler et al., 2019; Zhu & Tan, 2019). It is their responsibility to protect learners and prioritize their safety. That includes equipping them with the necessary tools, such as situation awareness, strong communication and mastery of difficult interactions. It also means empowering learners to take action if mistreatment occurs.

Learners should know that if they do not feel psychologically or physically safe at any point throughout a care interaction with a patient, family member or visitor, they are allowed to remove themselves. As soon as they have left the situation, they should seek help immediately (Warsame & Hayes, 2019; Zhu & Tan, 2019).

Ideally, patients with a known history of learner mistreatment should not be assigned to learners. However, if the interaction cannot be avoided, options for increasing safety include reassigning the learner or supervising encounters with the patient (Zhu & Tan, 2019).

Creating a psychologically safe and brave space allows for better outcomes and more rewarding learning experiences. Most of all, it can help mitigate the negative impact of mistreatment.

A psychologically safe and brave space is one where people feel comfortable admitting mistakes, where they learn from failures rather than blaming others and where they can openly share diverse views and ideas. Specific antecedents and outcomes of psychologically safe spaces in work settings have been identified (Edmondson, 2018; Frazier et al., 2017).

Factors that promote psychological safety include:

- role clarity
- peer support
- interdependence
- learning orientation
- positive leader relations.

Outcomes of psychologically safe spaces include:

- more information sharing
- higher satisfaction
- active learning (seeking information, experimenting, reflecting)
- deeper engagement
- improved performance, innovation and decision making.

Getting help – from whom?

Learners should be provided with all the options for seeking help. Options may differ among TAHSN hospitals, so explaining them should be part of the onboarding process at each site. Learners should know which TAHSN personnel they can contact for support if they experience mistreatment. It is also important for learners to know which TAHSN personnel they can go to for support outside of their direct faculty/supervisor. This provides flexibility and a larger pool of people for learners to access. It also ensures that learners get the support they need if they cannot get it from their direct supervisor. Examples of TAHSN personnel are education coordinators, preceptors, supervisors, managers, senior staff and student advisory council leads.

Using the ERASE framework

One model that may help faculty and supervisors support learners is the ERASE framework (Wheeler et al., 2019; Wiesenfeld, n.d.; Wilkins et al., 2019).

ERASE stands for:

Expect that mistreatment will happen and prepare accordingly. This means that you should work on developing your own knowledge. Rehearse specific language so you can provide anticipatory guidance to learners. It is also important to set the tone that mistreatment will not be tolerated.

Recognize mistreatment. This means taking time to understand the various ways mistreatment can occur, particularly subtle forms of mistreatment that may easily go unnoticed.

Address the situation in real time. Addressing mistreatment as soon as possible allows learners to explain the impact of the incident while it is still fresh in the minds of the people who were involved or who witnessed it. For more guidance in intervening in the moment, consider the GRIT framework (described on page 13 of this guide).

Support the learner after the event. Do not make assumptions after an incident of mistreatment. Check in with the learner to determine when and how they would like to debrief the situation (now vs. later; as a team or individually, etc.) (Bullock et al., 2021). Ask learners how they experienced the event. Listen and respond to concerns, and support learners in making decisions about next steps. (See "Post-incident debriefing and support" section for more information on the debriefing process.)

Establish/encourage a positive culture. Create a culture that is psychologically safe and a space that is brave, in which learners can share and feel supported. Check in with the learner about how you responded in the moment and ask whether they want or need something different from you if a similar event happens again. This is an opportunity to shift power to the learner and re-establish the best way for you to provide ongoing support (Bullock et al., 2021). This can promote a positive learning environment.

APPLYING A TRAUMA-INFORMED LENS

Working with patients and family members requires learners to recognize that trauma is common. For example, 32 per cent of adults in Canada report that they experienced abuse in childhood and 25 per cent of students in grades 6–12 report being bullied (Public Health Agency of Canada, 2018). This suggests that many people seeking services in health care and other systems have been exposed to some form of trauma (Butler et al., 2011).

Trauma results from an event, series of events or set of circumstances that a person experiences as physically or emotionally harmful, or life-threatening. It has lasting adverse effects on the person's functioning and on their mental, physical, social, emotional and spiritual well-being (Substance Abuse and Mental Health Services Administration, 2014).

Trauma must be understood from the person's experience because, "no two people will experience the exact same thing, in the exact same way" (Sweeney et al., 2018). Some people feel the effects of trauma immediately, but others do not begin to feel them until long after the event. These effects may be short-lived or they may recur throughout the person's life.

A trauma-informed lens sets the groundwork for engaging with patients, families and visitors. This universal approach should underlie all care interactions, even when the personal history is unknown. This approach benefits everyone, whether or not they have experienced trauma (Public Health Agency of Canada, n.d.).

NOTE: Trauma-informed care differs from trauma-specific care, which is a highly specialized type of care that directly addresses the symptoms of trauma in someone who has actually experienced it.

Adopting a trauma-informed lens focuses on enhancing safety and minimizing harm. It seeks to reduce barriers to care and promotes strategies for more compassionate, person-centred and non-judgmental care (Canadian Public Health Association & Centre for Sexuality, 2020).

Trauma-informed care involves various routine practices (CAMH Trauma-informed De-escalation Education for Safety and Self-Protection [TIDES], 2022a). These practices include the following:

- Advocate and provide access to peer-based services.
- Attempt to communicate collaboratively and achieve mutual respect.
- Examine how historical context such as culture, racialization, colonization, oppression and gender-related issues may contribute to a person's behaviour.
- Demonstrate trustworthiness and transparency.
- Practise self-awareness self-reflection and self-management strategies.
- Empower patients and offer choices and control whenever possible.

See Appendix 1 for more information about interacting with people in a trauma-informed way.

To create safer and therapeutic spaces, learners must be aware of these principles and use them to help guide practice, interventions and engagement. By doing so, learners can help facilitate safety, mitigate the effects of trauma and prevent further harm.

PRE-BRIEFING THE LEARNER

The response to mistreatment can occur before an incident takes place. As outlined in the ERASE framework, it is important to expect mistreatment and to prepare for it. Discussing mistreatment and possible responses with learners can result in more effective responses that actually support the learner (Bullock et al., 2021).

Each learner brings their own unique identity and experiences, which means that they will have different preferences for how their faculty/supervisors respond to microaggressions (Bullock et al., 2021).

Discussing the learner's unique preferences for how to respond transfers power from the faculty/supervisor to the learner, which can help the learner feel like they are respected and the expert on their own experience. Having the conversation about microaggressions before they occur signals to learners that their psychological safety is a priority and promotes a culture of safety.

How to pre-brief (Bullock et al., 2021):

- Have a discussion with your learner at the start of their rotation as part of their orientation to help you get to know them and their needs.
- Discuss how the learner would like you to address microaggressions (this may include responding in different ways depending on the source [patient vs. colleague] and the context [acute medical situation vs. non-acute situation]). For example, responses may be delayed if a patient is acutely unwell and responding in the moment may escalate a situation (see "Mistreatment response flow chart" on page 24).
- The discussion about dealing with microaggressions can start with a larger group of learners, followed by one-on-one discussions with each learner about their unique preferences.

Some learners may not know how they want you to respond, so checking in with them regularly, as well as after an incident of mistreatment will prepare them and you for any future mistreatment. You can also give the learner options for communicating their wants or needs in the moment (Bullock et al., 2021).

It is important for learners to know at the outset that they will not be penalized for their preferred response to mistreatment (e.g., if a learner wants to be reassigned to a different patient, it will not affect their assessment results for the placement) (Bullock et al., 2021).

RESPONDING TO MISTREATMENT IN THE MOMENT

When mistreatment occurs, it can be challenging to respond in the moment and maintain a trauma-informed lens. In these moments, learners are faced with trying to process the incident while having to maintain a therapeutic alliance and a compassionate approach with patients and their families. Confronting the inappropriate or offensive language or behaviour can be difficult and deeply uncomfortable (Wheeler et al., 2019; Zhu & Tan, 2019). It can increase stress and contribute to moral distress and other forms of physical and psychological suffering. If mistreatment is not addressed, the cumulative effect of this distress can lead to burnout.

Promoting the growth of learners as professionals requires helping them develop skills to support themselves in the moment when mistreatment occurs, as challenging and uncomfortable as this may be.

The GRIT structure is a mnemonic that learners can use to address mistreatment in the moment while they continue to interact with the person in a trauma-informed way (Warner et al., 2020; Wheeler et al., 2019). This simple memory aid allows learners to cognitively rehearse and prepare themselves for situations where mistreatment may occur. The section below describes these strategies and provides sample statements to use with learners (Human Rights and Health Equity Office at Mount Sinai Hospital, n.d.; Warner et al., 2020).

G – Gather your thoughts

Pause and take a moment to gather your thoughts before reacting to the offensive comment or behaviour. Situations of mistreatment can trigger emotional and physiological responses. Those responses are valid. Learning how to regulate affect and manage reactions in the moment builds resilience, promotes sound decision making and increases safety during a situation. Once you are composed, decide whether it is an appropriate time or place to address the perceived mistreatment.

See Appendix 2 for more self-management strategies.

R – Restate

Approach the person by repeating the comment or describing the behaviour you are concerned about. Another option is to ask them to restate their comment or describe their behaviour themselves. Allowing the person to clarify can help you better understand their beliefs and opinions. This can help them or their family member realize the potential negative impact of their words or behaviours and gives them space to make a change.

Here are two examples of how to restate:

"I don't know if you know how that sounded, but the way it sounded to me is that you think _____"

"What do you mean by _____?"

I – Inquire

Seek further clarification. Using the universal principles of trauma-informed interactions, ask more questions to help you understand why the person spoke or behaved in an offensive way. Conversation can also provide opportunities to strengthen the therapeutic alliance, express empathy for the patient's difficulty without endorsing the offensive comments or actions, and offer corrective feedback.

Here are two examples of how to inquire:

"Help me understand what you meant by that comment."

"I think I hear you saying that all _____, are _____. Is that what you mean?"

T – Talk it out

Discuss the potential impact of the behaviour or comments on others and your personal perception of the incident. Using "I" statements is one way to focus on personal impact and on your perspective in a non-judgmental manner. It is important to understand that describing one's own emotions is different than responding with emotion. Also try to separate the person from the offensive comment or behaviour, thus "depersonalizing" the offence.

Here are two examples of how to talk it out:

"In my experience, that comment may perpetuate negative stereotypes."

"When you said [did] _____, you are reinforcing negative stereotypes of _____, and that can affect how we provide care [or teach or treat our colleagues]."

Know when to walk away. Be aware that you can leave any care interaction that is unsafe and get help from a senior staff member, team lead, faculty/supervisor or manager.

The GRIT framework can also be used by faculty/supervisors to support the learner in the moment. As an ally, remember not to try to take over unless the person specifically asks you to. It is important to think about doing "with," not "for" (Human Rights and Health Equity Office at Mount Sinai Hospital, n.d.).

RESPONDING TO MISTREATMENT WHEN IT ESCALATES[1]

In cases where the situation escalates, the learner can consider using de-escalation strategies to support communication with the patient, family member or visitor. In this context, learners must consider their own physical safety. If they are alone with the person and their physical safety is at risk, they should remove themselves immediately and seek help.

If the person displays behaviour that indicates an immediate risk of bodily harm to themselves or others, the learner should consider calling a **Code White**. This emergency code initiates a team-based response. Learners should familiarize themselves with the emergency response at their TAHSN hospital.

If the learner feels comfortable, they can engage in de-escalation. This dynamic process involves **engaging safely**, **clarifying the issue** and **resolving the issue**. However, these strategies are only effective if the de-escalator is managing their own emotions and engaging with empathy and respect.

The five pillars of effective de-escalation are described below.

1. Engage safely

Assess risk (person and environment) in order to plan for safe engagement. Be mindful of your proximity to the person. Keeping a safe distance means being able to see the person from head to toe using peripheral vision (Figure 2).

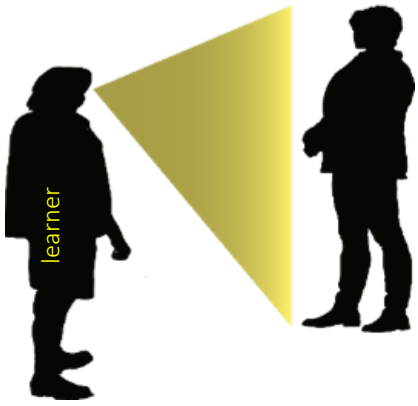

Figure 2. Keeping a safe distance to engage the person

[1] The content in this section is from an e-learning course about collaborative de-escalation developed by CAMH TIDES (2022b).

Strategies for safe engagement include the following:

- Remind the person that you are here to help.
- Set limits in a non-confrontational and mutually respectful way.
- Be aware of the exits and do not block them. Allow for movement in the space where possible.
- Conduct an environmental assessment for any hazards (i.e., objects and people that might contribute negatively to the situation).
- Speak clearly, using language the person will understand, and be mindful of para-verbal communication.
- Move slowly and intentionally.
- Enlist the support of a staff and/or call a Code White.

2. Clarify

Take the time to understand the situation and the person's perspective. By seeking to understand the situation better, you can facilitate mutual goal setting and ensure safety for both yourself and the other person.

Strategies for clarification include the following:

- Assess the acuity of the person's medical or psychiatric situation. Here are questions to consider when assessing acuity (Whitgob et al., 2016):
  - How sick is the patient? Does their medical or psychological problem limit their ability to interact?
  - Is the patient's condition emergent or is their cognitive/mental state unstable?
  - Does the patient have immediate medical needs that require intervention?
- Engage in active listening and ask open-ended questions to allow the person to express themselves.
- Provide clear, truthful information in a way that will be best received and understood by the person.
- Paraphrase the person's understanding of the situation and check for alignment.
- Clarify misunderstandings or confusion. Redirect the conversation to focus on the care.
- Allow for moments of silence (i.e., attempt to slow down the interaction to give the person time to process what is happening).

3. Engage with empathy and respect

Empathy and respect are the foundations for all interactions and are guiding principles for being trauma informed. Empathy is the ability to identify and acknowledge a person's emotional state without experiencing that state yourself. It is grounded in non-judgmental acceptance and openness. Leading with empathy allows us to better understand the person's perspective.

Understanding the person's experiences, risk factors, history and coping skills (healthy and adaptive) helps you to support the person by meeting their needs and mitigating factors that can cause distress.

Strategies for engaging with empathy and respect include the following:

- Validate by acknowledging the person's frustration.
- Validate by labelling the person's feelings and the needs they express.
- Allow for simple, causal human exchanges in the interaction. Look for areas of connection.
- Allow the person moments to vent frustration verbally.
- Don't criticize or argue.
- Be mindful of your verbal (choice of words) and non-verbal communication.

4. Practise self-management

Self-management is the degree to which you are able to control yourself and your behaviour under stress. Exploring strategies to regulate these responses is essential. Examples of self-management in the moment include breathing mindfully and using grounding techniques.

Other strategies to support self-management in the moment include the following:

- Maintain a normal rate of speech and an indoor speaking voice.
- Use language that is clear and concise.
- Maintain a relaxed facial expression and display a neutral emotional response to insults.
- Avoid defensive body language.
- Avoid moving quickly or abruptly.
- Allow for moments of silence in conversation.

See Appendix 2 for more self-management strategies.

5. Resolve

The desired outcome of the de-escalation process is coming to a resolution and preventing further escalation. Strategies to use when attempting to find a resolution include the following:

- Include the patient and/or their family member in decision making or problem solving.
- Elicit the patient's preferences and ideas for support, as well as other acceptable alternatives.
- Offer choices where possible.
- Apologize if it is appropriate to do so and offer to make a change.
- Connect the patient to appropriate resources.

- Support the patient in challenging or addressing identified injustices.
- Review the plan with the patient and check for agreement.
- Conclude the visit by reiterating any agreed upon next steps.

See Appendix 3 for how you can be an ally if you observe a fellow learner experiencing mistreatment.

POST-INCIDENT SUPPORT

It is vital that learners are offered an opportunity to reflect on and discuss incidents of mistreatment with others (team, faculty/supervisor, trusted colleague), even if they were not the direct target of the mistreatment. The discussion can be held on a one-on-one basis or as a group. It should happen immediately after the incident if possible or at a time that the learner prefers (CAMH TIDES, 2022c; Wheeler et al. 2019; Wiesenfeld, n.d.; Wilkins et al., 2019; Williams et al., 2019; Zhu & Tan, 2019).

Faculty/supervisors may feel unequipped to support learners when mistreatment occurs. Acknowledging their own discomfort can help to promote a discussion.

It is equally important for faculty/supervisors to engage in personal reflection. They should consider how they respond and be aware of their own biases and gaps in knowledge. Self-reflection will help them to respond more effectively in the future.

Recommended steps when checking in with a learner about a mistreatment experience include the following:

1. Actively listen to the learner's experience and validate their feelings and experiences.
2. Ask the learner to reflect on what they were thinking, what emotions they felt, how intense the experience was and how they felt physically. These questions will help the learner improve their self-awareness.
3. Ask the learner how they responded and how they wish they had responded.
4. Ask the learner to reflect on past experiences and note what differed in their response. Consider how the learner might adjust their response if they experience mistreatment again. Offer guidance. If you were present during the incident and responded, ask the learner if they wish you had responded differently.
5. Support the learner's growth by using strategies listed above and other cognitive rehearsal exercises or practices. Consider all resources available through the hospital and academic institutions.
6. Encourage the learner to continue reflecting and noticing their own reactions because the experiences of mistreatment can sometimes cause thoughts or feelings to linger or show up later.
7. Share your own experiences and learnings where appropriate.

8. Offer immediate support. Ask, "What can I do to support you? I won't do anything unless you want me to, but I'm here if you need me."
9. Support the learner in achieving closure. Suggest counselling resources. Consider culturally specific resources, spiritual services, psychological services or peer support services.
10. Encourage self-care. (See "Practising self-care and wellness" section.)
11. Decide with the learner what information from the incident should be shared with the team.
12. Review all documentation and reporting that needs to be completed. If required, support the learner in reporting the incident.
13. Offer ongoing check-ins or supervision to ensure that the learner received adequate supports.
14. If discussion with the learner identifies gaps in processes, supports and resources for addressing mistreatment, support the learner by advocating change.

Continuing a therapeutic relationship after mistreatment

Discuss the continuation of the therapeutic relationship between the learner and the patient (Zhu & Tan, 2019). Allow the learner to guide this decision. If they decide to continue the relationship, plan possible next steps for future interactions they will have with the patient and their family. Discuss how to set expectations with the patient and what to do if mistreatment occurs again. Make a plan for ongoing supervision to support the learner as they continue to work with this patient or family member.

DOCUMENTING AND REPORTING MISTREATMENT

Documenting and reporting mistreatment will be unique to each TAHSN setting and to each profession. Documentation may include clinical notes and safety reporting procedures.

It is important for learners to know that **all mistreatment should be reported** (Warsame & Hayes, 2019; Zhu & Tan, 2019). Reporting all occurrences of mistreatment builds awareness and promotes education. It also provides data to TAHSN hospitals about the frequency of these occurrences. Collecting data is essential in gathering the knowledge, better understanding mistreatment and building processes to mitigate and address mistreatment in all its forms.

PRACTISING SELF-CARE AND WELLNESS[2]

Learners are already navigating and managing a variety of stressors in both their personal and professional lives. When mistreatment occurs, it can increase stress. Experiences of mistreatment can have significant lasting psychological impacts, such as burnout, low self-esteem and confidence, and decreased interest in pursuing a career in medicine (Haviland et al., 2011; Heru et al., 2009; Zhu et al., 2019).

See Appendix 4 for more information on managing and mitigating burnout.

Resilience can buffer the negative psychological outcomes of stress. This means that a faculty/supervisor should support the learner in caring for their health and well-being. The process of building resilience can be challenging. The learner should know that wellness is a dynamic and ever-changing process. The aim of the wellness plan is to help the learner regain internal balance. The plan should be goal-oriented and self-directed. Effective wellness plans include both micro-strategies and macro-strategies.

Micro-strategies for supporting wellness

Micro-strategies are short practices that help a learner recharge during work and help them regain the ability to engage actively and productively. Here are some examples:

- engaging in movements to dispense or add energy
- finding opportunities to laugh
- monitoring hydration and nutrition
- participating in end-of-day/shift rituals
- practising self-regulation
- reducing time spent with energy-consuming people and processes
- taking breaks.

Macro-strategies for supporting wellness

Macro-strategies are longer-term practices that support overall wellness. The domains of wellness can be a helpful framework that a learner can use to make their own self-care plan (Figure 3 on next page).

[2] The content in this section is from an e-learning course about burnout developed by CAMH TIDES (2022d).

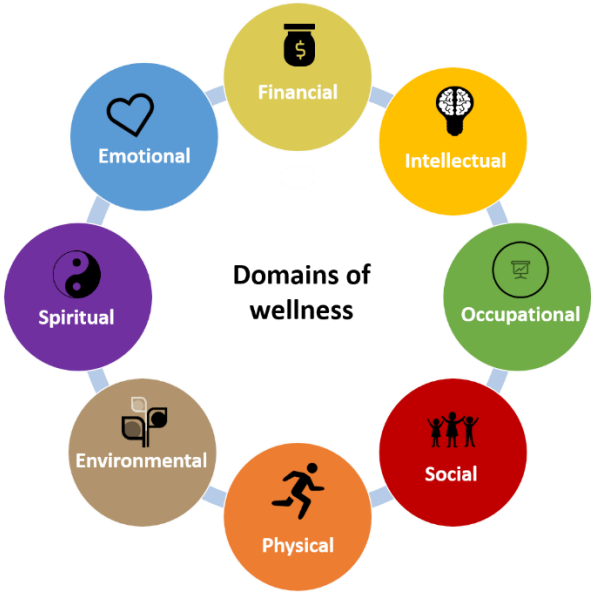

Figure 3. Domains of wellness to consider in a self-care plan[3]

Here are eight life domains in which a learner can practise self-care:

- Emotional:
  - Acknowledge, explore and respect your feelings, values and attitudes, and those of others.
  - Look for ways to feel positive and enthusiastic about your life (e.g., through mood-lifting activities such as hobbies, reading, learning, music, movies, writing).
- Environmental:
  - Demonstrate a commitment to healthy spaces.
  - Explore how the social, natural and human-built environments affect your health and well-being.
- Financial:
  - Make informed financial decisions and set realistic financial goals.
  - Recognize that everyone's financial values, needs and circumstances are unique.
- Intellectual:
  - Explore new ideas and different points of view.
  - Respond positively to intellectual challenges.
- Physical:
  - Care for your body to stay healthy (e.g., exercise, nutrition, sleep).
  - Consider what healthy habits make you feel better and suit your lifestyle and level of mobility and fitness.

[3] This figure is adapted from "8 dimensions of wellness" on the Your Guide to Living Well blog. This adapted version was originally developed for the CAMH TIDES curriculum.

- Social:
  - Care about others and allow others to care about you.
  - Connect and contribute to the community (e.g., through advocacy, accessing allies and finding creative solutions, arguments and responses to unresponsive systems).
- Spiritual:
  - Find purpose, value and meaning in your life.
  - Participate in activities that are consistent with your beliefs and values.
- Occupational:
  - Prepare for and participate in work that provides personal satisfaction and life enrichment, while also being consistent with your values and goals.

TAHSN supports and resources for learner wellness

All TAHSN hospitals acknowledge that a learner's wellness can only thrive in an environment free from violence, racism, discrimination, bullying and toxicity of any kind. Learners should receive information about where to find and how to access resources to support their wellness through their hospital and affiliated schools. Some examples of resources are student centres and internal websites.

RESPONDING TO INCIDENTS OF MISTREATMENT FLOW CHART

Responding to Incidents of Mistreatment Flow Chart is a suggested guide for decision making and response when navigating situations of actual or potential learner mistreatment (see the flow chart on page 24). The flow chart provides two common scenarios where mistreatment may occur and highlights key considerations for learners when navigating these situations, such as:

- comfort level of the learner during the interaction
- rationale behind a request for change of service provider
- presence or absence of a form of mistreatment
- assessment of the patient's health and mental health status and acuity of health concern
- potential effects of granting or denying the request
- observation of escalation of behaviours or imminent risk of harm in the current situation.

The flow chart suggests responses based on the assessment of the key considerations noted. Potential responses include disengaging and getting support, using safe engagement and self-management strategies, maintaining a trauma-informed lens and identifying the most appropriate response to the request.

This flow chart has been adapted from UHN's Addressing Caregiver Preference Requests Guidelines and the Mayo Clinic's Algorithm for Response to Inappropriate Patient or Visitor Behaviour or Request for Specific Clinician Flow Chart.


Scenario 1
Patient, family member or visitor requests a different service provider (does not want to work with learner)
Scenario 2
Patient, family member or visitor mistreats learner during intake, assessment or ongoing therapeutic interaction
Does the learner feel comfortable continuing the interaction?
NO
STOP
Disengage and get help from a senior staff, team lead, supervisor or manager.
Make a plan on how to best move forward with the request.
Be prepared to call a code if needed.
Report, document and debrief.
YES
Inquire about the reason for the request. Apply a trauma-informed lens.
NO
Does the learner feel comfortable to continue?
NO
Is the reason a form of mistreatment?
YES
YES
Learner should:
Keep a safe distance and be prepared to call for help if the behaviour escalates.
Use GRIT tool for responding to mistreatment in the moment.
Continue to maintain a trauma-informed lens.
NO
Is a physical health condition emergent or is mental state unstable?
YES
Grant request with guidance from supervisor to determine feasible and appropriate accommodations
Is the behaviour of the patient, family member or visitor escalating?
YES
Is there risk of imminent harm?
YES
STOP
Learner should remove themselves immediately and call a Code White.
Report, document and debrief
NO
Is the basis of the request any of the following?
culturally appropriate
religiously appropriate
related to previous trauma
YES
NO
Does learner feel safe to continue?
NO
STOP
Disengage and get help from senior staff, team lead, supervisor or manager.
Plan how to best move forward with the request.
Be prepared to call a code if needed.
YES
Learner can attempt de-escalation:
Engage safely.
Self-manage.
Clarify.
Resolve.
Lead with empathy and respect.
Be prepared to seek support or call a code.
Will patient's health be adversely affected if the request is not granted?
YES
NO
Deny request and provide a rationale. Remain trauma-informed.
Report, document and debrief.

HOSPITAL RESOURCES

Learners and faculty/supervisors should identify and become familiar with the resources available at their respective hospitals that can support learners. This should include reviewing organizational policies and visiting the hospital's student centre.

APPENDIX 1: UNIVERSAL TRAUMA-INFORMED APPROACHES FOR SUPPORTING PATIENTS, FAMILIES AND VISITORS[4]

Trauma-informed principles	Strategies or actions
Trauma-informed lens	Maintain a trauma-informed lens. If someone responds in an unexpected way, pause and reflect on "what happened to this person?" • Seek to understand the person's perspective. How may trauma influence emotions and behaviour even when anger, frustration, sadness, loneliness, etc. are observed? • Recognize that adaptive behaviours may be the person's way of coping with trauma and that they may not be aware of the many adaptive methods they have used to survive. • Reframe behaviours from a strengths-based perspective to emphasize resilience.
Social impact	Consider how the social and structural impacts of oppression contribute to individual and systemic bias, which perpetuate inequitable systems and practices. • Reflect on your own prejudices and bias. What are your beliefs, values and theories about people (e.g., with mental health and substance use disorders)? Seek to unlearn these perspectives. • Acknowledge trauma caused by colonialism, racism, poverty, sexuality-related phobia, sexism, etc. • Recognize that your health care training may have blind spots to care. Recognizing these gaps may reduce inequities related to culture, history, gender and others forms of structural oppression.
Mutual respect	Attempt to collaborate and cultivate mutual respect. • Ground communication in empathy and in being open, flexible and non-judgmental. • Be patient-centred. Listen, believe and validate experiences, thoughts, feelings and emotions. • Emphasize mutual goals.

[4] This information is adapted from Sweeney et al. (2018).

	• Use culture as a way to ground patients and provide a sense of meaning, self-perception, purpose and belonging.
Safety	Create and advocate emotional, psychological, physical, social, gender and cultural safety for the people you serve. • Foster honest dialogue where patients can share their concerns. You can facilitate this open exchange by acknowledging topics pertaining to human dignity, equity and justice. • Remember that growth depends on confronting issues that may be uncomfortable. • Encourage privileged people to challenge their own preconceptions by promoting a culture where mistakes are acceptable in the process of learning about different topics. • Understand power and privilege in the relationship.
Trustworthiness	Demonstrate trustworthiness and transparency. • Follow consistent and reliable practices. • Set respectful boundaries. • Be honest and show genuine concern. • Use direct rather than clinical language to describe human experiences (this includes using visual aids or getting interpretation services).
Empowerment	Whenever possible, empower the person, provide choices and give them control. • Adopt a strengths-based approach and promote skills that help the person develop autonomy and take control of their care and recovery. • Allow for shared decision making and invite feedback at all levels of care. • Support choices that promote self-determination. • Offer to connect with patient advocacy offices. • Avoid coercion and other controlling practices.
Peer support	Advocate access to peer supports. • Offer to connect with patient advocate offices and other supports. • Activate support networks for patients and families.

Self-awareness	Pay attention to your own responses. • Recognize when you are experiencing countertransference, moral distress or vicarious trauma; exposure to traumatic events may trigger various responses in different people. • Create a plan to deal with these responses in order to protect your well-being and build your resilience. Being balanced and well means you are present physically and psychologically for both your team and your patients. • Work on building your own de-escalation skills to support patients in distress.

APPENDIX 2: SELF-MANAGEMENT STRATEGIES[5]

For a learner who has experienced mistreatment, self-awareness involves reflecting on oneself and recognizing factors that contribute to their personal reactions (physical, cognitive and emotional) in situations where emotions are heightened. It is valid to have reactions and emotional responses to mistreatment. These positive or negative responses can influence our ability to control our thoughts and emotions and can decrease our ability to focus and problem solve. Therefore, having a better understanding of these responses might help learners engage in self-management strategies and seek the appropriate supports.

Self-management is the degree to which you control your emotional responses and behaviours when you are under stress or in distress. Here are some techniques to help you self-manage:

1. Breathe mindfully. Repetitive and controlled breathing can slow your stress response. It helps calm the body and mind so you can think clearly and respond effectively. Box breathing is a mindful breathing technique that helps you focus on your breath:
    - Inhale for 4 seconds.
    - Hold that breath for 4 seconds.
    - Exhale for 4 seconds.
    - Repeat.

2. Focus on one task, step or goal. This can minimize stimulation and allow you to be fully present in the moment.

3. Ground yourself through movement to help relax tension and focus on the present. Examples include changing body position, clasping hands, placing both feet on the ground, wiggling your toes (Therapist Aid, 2018).

[5] The content in this section is from an e-learning course on self-awareness and self-management developed by CAMH TIDES (2022c).

APPENDIX 3: BE AN ALLY: WHAT TO DO AS A LEARNER IF YOUR PEER IS EXPERIENCING MISTREATMENT[6]

An ally is someone who recognizes the unearned privilege they receive from society's patterns of injustice and takes responsibility for changing these patterns.

Being an ally is an ongoing practice where one is consistently doing the work (learning, unlearning and re-evaluating) to recognize their privilege and how it can lead to biased attitudes and behaviour.

What are the qualities of an ally?

- Self-reflective
- Empathetic
- Willing to take risks
- Willing to keep learning and stay informed
- Ready to listen to others' experiences
- Open to new ideas and perspectives
- Willing to make mistakes and keep trying to do the right thing
- Able to identify and respond to oppression
- Willing to embrace and work through all emotions that may emerge when we honestly reflect on power and privilege that may lead to bias, beliefs and attitudes

Allies acknowledge that there are injustices in society and that people who have been given more power and privilege based on their identities have a responsibility to respond to any form of oppression in their communities. Here are some examples of ally behaviour:

- Be aware of and vigilant of your own prejudices.
- Avoid making assumptions about a person's behaviour and identity based on their appearance.
- Question stereotypes and negative assumptions made by others.
- Challenge practices, policies and procedures that may create barriers for specific people and groups.
- Actively speak out against discrimination within your networks and circles.
- Join collective social justice movements in your communities that work toward creating systemic change to dismantle oppression.

[6] The content in this section is adapted from an article on the University of Toronto website called "Allyship and inclusion at the Temerty Faculty of Medicine."

If you observe that a fellow learner is experiencing mistreatment, follow these steps to respond safely and help them:

1. Speak up when you hear any forms of mistreatment (e.g., demeaning jokes, offensive or stereotypical remarks, microaggressions, discriminatory/harassing comments).
2. Discourage the use of disrespectful or derogatory language to describe people and groups.
3. Support the learner's choice to remove themselves from the situation.
4. Acknowledge the effects of the mistreatment and label it as such.
5. Offer to discuss and debrief the situation. Create space for this discussion and allow the learner to debrief in their own time.
6. Listen more than you speak, and do so with empathy.
7. Strengthen and enhance resilience.

APPENDIX 4: BURNOUT[7]

The World Health Organization (2022) defines burnout as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed." Burnout is characterized by a reduced sense of personal accomplishment, depersonalization and emotional exhaustion. Research shows that burnout is correlated with depressive symptoms, and that emotional exhaustion is associated with:

- substance use
- poor physical health
- anxiety
- lower self-esteem
- poorer overall quality of life for health care. (Maunder et al., 2021)

People do not experience burnout in the same way, and challenging situations can affect some people more than others. The chart below highlights symptoms that can be related to burnout.

Physical symptoms	Emotional symptoms	Behavioural symptoms	Cognitive symptoms
• Fatigue • Headaches • Difficulty sleeping • Muscle tension or other physical pain or discomfort • Stomach problems (e.g., nausea, diarrhea, vomiting) • Loss of sex drive • Rapid heart rate • High blood pressure	• Anger • Fear • Anxiety • Moodiness • Low morale • Irritability • Hopelessness or helplessness • Apprehension • Depression • Unhappiness or guilt • Agitation or inability to relax	• Changes in eating or sleeping patterns • Social withdrawal • Nervous habits (e.g., nail biting, teeth grinding, foot tapping) • Neglect of family or work responsibilities, affecting interpersonal relationships • Increased use of caffeine, cigarettes, alcohol or other addictive behaviours • Decline in performance or productivity	• Difficulty concentrating or thinking • Memory problems • Negativity or lack of self-confidence • Constant worrying • Difficulty making decisions

[7] The content in this section is from an e-learning course on burnout developed by CAMH TIDES (2022d).

Strategies for managing burnout and other work-related stress

1. Self-regulation: Restoring health to the brain and body

- Box breathing or other mindful breathing exercises
- Focusing on one task, step or goal to minimize stimulation
- Laughter
- Positive self-talk
- Releasing physical tension through stretching or grounding movements
- Seeking support and connection from others
- Social connection
- Visualization

2. Cognitive diffusion: Getting free from sticky thoughts

Goal setting	When distressing thoughts arise, use them to set goals. This engages the regions of the brain associated with planning, coordinating and rational thought. It can give a sense of control, help manage anxiety and prevent feelings of being overwhelmed when many demands are placed on you.
Leaves in a stream	Start by visualizing a stream with leaves floating on the surface. When you notice a thought entering your mind, imagine placing it on a leaf and letting it float away. You can do this with every thought, regardless of whether it is pleasurable, painful or neutral. If it feels like your thoughts have stopped, continue to watch the stream because your thoughts will certainly start up again. It helps to be open and curious as you watch your thoughts come and go, and to be patient with thoughts that might hang around.
Spot and shift	Identify and name each thought as it arises (e.g., "I'm worried about my family's health"). Then shift to the role of thinker by saying it to yourself (e.g., "I'm having this thought about my family's health"). Then shift to the role of observer by noticing the thought (e.g., "I notice I'm having this thought about my family's health"). It can help to say these phrases aloud, but if this is not possible, you can note them mentally or write them out.

Name it to tame it	This is like the spot-and-shift method. It involves identifying and describing the thoughts that arise. When an experience is translated into language, it can make it easier to understand. It moves the experience of the emotion from the amygdala, which feels things intensely, to the higher parts of the brain that can access memories, experience, judgment and planning. This can lessen the intensity of the emotions and provide a sense of control.

3. Personal values and meaning: Navigating moral distress

Reflect on your values and identity	Acknowledge what is happening and take time to reflect. For example, consider the following questions: • What is most important to you (e.g., related to this situation or at work/life in general) and why? • How have your values strengthened, shifted or weakened as a result of this situation? • What were some of the challenges presented by this situation? • What were you able to accomplish as a result?
Move toward your values	When you can engage in behaviours that align with your values, it might not change the situation, but it can help you stay connected to your understanding of yourself. Try to find any actions that match your values (e.g., simple acts of kindness).
Reconnect with yourself by connecting with the world around you	Find time for moments when you can seek peace and tranquility. For example, spend time in nature, worship/prayer and meditation/relaxation. Do this alone or with others (e.g., a pet, family member, friend).
Recognize decision points	When you experience stress and can choose what to do and how to behave, you are at a decision point. Take time to notice the difficult feelings, consider what you can do to support yourself, and then act.

GLOSSARY

Academic staff: All personnel who provide instruction, conduct research or work in academic administration. This includes people who are employed as professors, associate professors, assistant professors, instructors, lecturers, librarians or the equivalent of any of those academic ranks. This category also includes people in leadership positions and those holding unpaid academic appointments.

Ally: Someone who recognizes the unearned privilege they receive from society's patterns of injustice and takes responsibility for changing these patterns. An ally could also be a member of the dominant group who acts against oppression. Such responsibility includes questioning policies and procedures, centring the person most affected (not being performative), standing up for others when they witness discrimination, harassment or offensive comments.

Anonymity: When someone reports mistreatment without providing their identity, with the understanding that the ability to respond to the report may be limited. When deciding whether to review an anonymous report, an institution may consider whether there is sufficient information to enable the review. A person who makes an anonymous report will not be able to participate in the review process or receive information about its outcome. It is also possible to come forward in person to discuss or debrief what has happened, but to request anonymity (i.e., be de-identified – in name alone or even in the content of the report) when moving forward.

Anti-racism: The active ongoing process of identifying and eliminating racism by changing systems, organizational structures, policies and practices and attitudes, so that power is redistributed and shared equitably.

Anti-oppression: Strategies, theories, actions and practices that actively challenge systems of oppression on an ongoing basis in one's daily life and in social justice and change work. Anti-oppression work seeks to recognize the oppression that exists in society and attempts to mitigate its effects and equalize the power imbalance in communities. It challenges the systemic biases that devalue and marginalize difference. Oppression operates at different levels, from individual to institutional to societal, and so does anti-oppression work.

Biomedical model: A focus on biological factors as the main cause and influence for illness and disorders. This model is deeply entrenched in most Western countries.

Brave space: Recognizes that mistreatment is likely to occur and challenges everyone to own their intentions and impacts. It allows for all members in the space to acknowledge and discuss events that have affected the emotional well-being of themselves or others. A brave space offers support to learners, allowing them to step in and out of challenging conversations with support for their learning.

Culture: An integrated pattern of learned core values, beliefs, norms, behaviours and customs that are shared and transmitted by a specific group. Some aspects of culture, such as food, clothing, modes of production and behaviour, are visible. Major aspects of culture, such as values, gender-role definitions, health beliefs and worldview, may not be as visible.

Code White: The emergency code designed to initiate a cautious, prescribed and least-restrictive response to a patient, hospital personnel or anyone who is displaying immediate risk of serious bodily harm to themselves or others.

Complaint: A written or verbal expression of concern.

Countertransference: This concept attempts to captures the thoughts and feelings that may emerge based on a health care practitioner's own experiences but that are induced separately and unexpectedly by a patient's behaviour and actions.

Disclosure: When someone witnesses or experiences a negative incident and then reports it to the appropriate organization (e.g., hospital, academic institution). Disclosing involves conveying information about a person's conduct to the institution to seek information about options for accessing safety, support or accommodations, and for reporting.

Discrimination: Unequal treatment based on ancestry, citizenship, colour, disability, ethnic origin, religion/faith/belief system, family status, gender expression, gender identity, marital status, place of origin, race, sex (including pregnancy) and sexual orientation. Discrimination can be direct, indirect, subtle or overt.

Diversity: This concept refers to the demographic mix of the institutional community and involves recognizing and respecting everyone's unique qualities and attributes, with an understanding of the different experience of members of groups that remain underrepresented in the organization.

Equity: This concept refers to the fair and respectful treatment of all people and involves creating opportunities and reducing disparities in opportunities and outcomes for diverse communities. It also acknowledges that these disparities are rooted in historical and contemporary injustices and disadvantages.

Equity-deserving groups (or equity-seeking groups): Groups that historically have been disadvantaged and excluded from institutions and decision making as a result of colonialism and systemic sexism, racism, ableism, homophobia and transphobia. These groups include women, people who identify as racialized, Indigenous, living with disabilities, 2SLGBTQIA, and people from minoritized faith groups, among others.

Family: Any person or group of people that someone identifies as being family or part of a significant circle of support.

Harassment: A course of vexatious or troublesome comments or conduct that the person knows, or ought reasonably to know, is unwelcome.

Intersectionality: The interconnected nature of social categories such as race, class, disability, sexual orientation and gender identity as they apply to a given person or group. Intersectional identities create overlapping and interdependent systems of discrimination or disadvantage.

Inclusion: The creation of an environment where everyone feels welcome and respected, focusing on groups that remain underrepresented. It means creating conditions in which everyone has the opportunity to fully participate, and everyone's talents are valued and celebrated.

Learner: Anyone at a TASHN setting who meets the definition of "student" according to each hospital's student policy. The learner may be registered at a high school or post-secondary institution as a student, undergraduate, graduate, postgraduate, resident, fellow, post-doctoral fellow or another trainee. This includes administrative and operational staff, allied health professionals, medical students and research personnel participating in clinical or non-clinical placements/practicum, residents and clinical fellows. Learners also include faculty members who are engaged in various teaching, research and administrative activities.

Microaggressions: These acts are generally indirect and can be unintentional. They can be experienced as a pattern of snubs, slights, put-downs and gestures that demean or humiliate people based on their belonging to a group, particularly people identified by gender, race/ethnicity, sexual orientation, immigration status or socioeconomic class. Members of underrepresented groups are often the subjects of microaggressions.

Mistreatment: Intentional or unintentional behaviours that show disrespect for the dignity of others. Mistreatment can involve a single incident or a pattern of behaviour, and can range from subtle gestures or comments to egregious actions. Any behaviour involving the mistreatment of another person compromises the learning environment. Mistreatment includes microaggressions.

Moral distress: The psychological state that arises when external constraints prevent a person from pursuing the right course of action.

Patient: A person who receives care from any of the hospitals that are part of the TASHN. It includes clients and other related terms.

Racism: Differential treatment of various racial groups by a dominant racial group rooted in the belief of the superiority of one group over the other. Racism takes many forms: it can be symbolic, embodied, psychological, institutional/systemic, everyday and interpersonal.

Experiences of racial discrimination, harassment and vilification can be affected by its intersection with other elements of identity, such as sex-gender, sexuality, disability and age.

- Everyday racism refers to the "mundane" elements of everyday life that are typically not recognized because these manifestations of racism have become so normalized that they are typically not identified as racism. Everyday racism refers to tone, language, a gaze, surveillance (in stores), differential service (being ignored in a store) and actions such as moving when an Indigenous, Black or racialized student is seated beside a person on the bus or in the classroom. Everyday racism is multidimensional, and its impact is substantial and cumulative.
- Gendered racism refers to the allocation of resources along racially and ethnically ascribed understandings of masculinity and femininity, as well as along gendered forms of race and ethnic discrimination.
- Interpersonal racism refers to attitudes, ideas and behaviours that support, and therefore reinforce, racial inequality. Interpersonal and systemic/institutional racism function both independently and in concert.
- Systemic/institutional racism refers to the arrangements and practices that maintain racial hierarchies and racial inequality. It comprises policies, behaviours and practices that are part of the social, cultural or administrative elements of an organization and that produce or maintain positions of disadvantage for racialized individuals.
- Racial discrimination refers to behaviour that impedes and disadvantages people by withholding benefits and opportunities from them due to their perceived race, colour, nationality, ethnicity and ethno-religious or national origin.
- Racial harassment refers to an incident or series of incidents that intimidate, offend or harm a person or group because of their perceived ethnic origin, race or nationality. It includes verbal and physical abuse, insults and name-calling, bullying, threatening behaviour, damage to property, displaying or sharing racially offensive material and encouraging others to commit racist acts.
- Racial vilification refers to a public act that inspires or provokes others to hate, have disrespect for or ruthlessly deride a person or group due to their perceived race, colour, nationality, ethnicity or ethno-religious or national origin.

Report: A formal complaint that is made by the learner to the organization. Reporting is when information about a person's conduct is conveyed with the intent that the institution formally reviews and potentially acts on the information.

Third-party reporting: A form of anonymous reporting where someone who has experienced mistreatment can report it through someone else who then accesses one of the established reporting mechanisms to report the experience.

Underrepresented group: People who belong to communities that are underrepresented due to societal patterns of injustice. Underrepresentation occurs along a variety of social identifiers and their intersections.

Vicarious trauma: The experience of bearing witness to atrocities that are committed against others. It is the result of absorbing the sight, sound, smell, touch and feel of the stories told in detail by survivors who are searching for a way to release their own pain. Vicarious trauma can be an occupational hazard and health care workplaces must work to mitigate it by building strong social supports for staff.

REFERENCES

Ali, D. (2017). *Safe Spaces and Brave Spaces: Historical Context and Recommendations for Student Affairs Professionals*. NASPA Policy and Practice series, no. 2. Retrieved from www.naspa.org/images/uploads/main/Policy_and_Practice_No_2_Safe_Brave_Spaces.pdf

Bullock, J.L., O'Brien, M.T., Minhas, P.K., Fernandez, A., Lupton, K.L. & Hauer, K.E. (2021). No one size fits all: A qualitative study of clerkship medical students' perceptions of ideal supervisor responses to microaggressions. *Academic Medicine, 96*(11S), S71–S80.

Butler, L.D., Critelli, F.M. & Rinfrette, E.S. (2011). Trauma-informed care and mental health. *Directions in Psychiatry, 31*, 197–210.

CAMH TIDES (Trauma-informed De-escalation Education for Safety and Self-Protection). (2022a). Patient- and Family-Centred Care and Trauma-Informed Care [E-learning course].

CAMH TIDES. (2022b). Collaborative De-escalation [E-learning course].

CAMH TIDES. (2022c). Self-awareness and Self-management in the Moment [E-learning course].

CAMH TIDES. (2022d). Burnout [E-learning course].

Canadian Public Health Association & Centre for Sexuality. (2020). *Trauma and Violence informed Care Toolkit for Reducing Stigma Related to sexually Transmitted and Blood-borne Infections (STBBIs)*. Retrieved from www.cpha.ca/sites/default/files/uploads/resources/stbbi/stbbi-tvic-toolkit_e.pdf

Cook-Sather, A. (2016). Creating brave spaces within and through student–faculty pedagogical partnerships. *Teaching and Learning Together in Higher Education, 18*. Retrieved from http://repository.brynmawr.edu/tlthe/vol1/iss18/1

Edmondson, A.C. (2018*). The Fearless Organization: Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth*. Hoboken, NJ: John Wiley & Sons.

Frazier, M.L., Fainshmidt, S., Klinger, R.L., Pezeshkan, A. & Vracheva, V. (2017). Psychological safety: A meta-analytic review and extension. *Personnel Psychology, 70*, 113–165. Retrieved from https://digitalcommons.odu.edu/cgi/viewcontent.cgi?article=1018&context=management_fac_pubs

Haviland, M.G., Yamagata, H., Werner, L.S., Zhang, K., Dial, T.H. & Sonne, J.L. (2011). Student mistreatment in medical school and planning a career in academic medicine. *Teaching and Learning in Medicine, 3*, 231–237.

Heru, A., Gagne, G. & Strong, D. (2009). Medical student mistreatment results in symptoms of posttraumatic stress. *Academic Psychiatry, 89*, 302–306.

Maunder, R.G., Heeney, N.D., Strudwick, G., Shin, H.D., O'Neill, B., Young, N. … Mah, L. (2021). *Burnout in Hospital-based Healthcare Workers during COVID-19*. Science Briefs of the Ontario COVID-19 Science Advisory Table. Retrieved from https://covid19-sciencetable.ca/sciencebrief/burnout-in-hospital-based-healthcare-workers-during-covid-19/

Human Rights and Health Equity Office, Mount Sinai Hospital. (n.d.). *What can an ally say?* [PowerPoint slides].

North York General Hospital. (2021). Learner mistreatment. Retrieved from www.nygh.on.ca/education-and-research/centre-education/students-and-residents/learner-assistance/learner-mistreatment

Public Health Agency of Canada. (n.d.). *Trauma and Violence-informed Approaches to Policy and Practice*. Retrieved from www.canada.ca/en/public-health/services/publications/health-risks-safety/trauma-violence-informed-approaches-policy-practice.html

Smith-Coggins, R., Prober, C.G., Wakefield, C. & Farias, R. (2017). Zero tolerance: Implementation and evaluation of the Stanford medical student mistreatment prevention program. *Academic Psychiatry, 41*, 195–199.

Substance Abuse and Mental Health Services Administration (SAMHSA). (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma14-4884.pdf

Sweeney, A., Filson, B., Kennedy, A., Collinson, L. & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances, 24*, 319–333.

Temerty Faculty of Medicine, University of Toronto. (n.d.). Allyship and inclusion at the Temerty Faculty of Medicine. Retrieved from https://temertymedicine.utoronto.ca/allyship-and-inclusion-faculty-medicine

Therapist Aid. (2018). Grounding techniques. Retrieved from www.therapistaid.com/therapy-worksheet/grounding-techniques

Warner, N.S., Njathi-Ori, C.W. & O'Brien, E.K. (2020). The GRIT (Gather, Restate, Inquire, Talk It Out) framework for addressing microaggressions. *JAMA Surgery, 155*, 178–179.

Warsame, R.M. & Hayes, S.N. (2019). Mayo Clinic's 5-step policy for responding to bias incidents. *AMA Journal of Ethics, 21*, E521–529.

Wheeler, D.J., Zapata, J., Davis, D. & Chou, C. (2019). Twelve tips for responding to microaggressions and overt discrimination: When the patient offends the learner. *Medical Teacher, 41*, 1112–1117.

Whitgob, E.E., Blankenburg, R.L. & Bogetz, A.L. (2016). The discriminatory patient and family: Strategies to address discrimination towards trainees. *Academic Medicine, 91*, S64–S69.

Wiesenfeld, L. (n.d.). Slide presentation, Geriatric Psychiatry Consultation Liaison Service, Sinai Health, Toronto, ON.

Wilkins, K.M., Goldenberg, M.N. & Cyrus, K.D. (2019). ERASE-ing Patient Mistreatment of Trainees: Faculty Workshop. *MedEdPORTAL, 15*. Retrieved from www.mededportal.org/doi/10.15766/mep_2374-8265.10865

Williams, J.C. & Rohrbaugh, R.M. (2019). Confronting racial violence: Resident, unit, and institutional responses. *Academic Medicine, 94*, 1084–1088.

Zhu, G. & Tan, T.K. (2019). Medical student mistreatment by patients in the clinical environment: prevalence and management. *Singapore Medical Journal, 60*, 353–358.