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Power Day: Addressing the Use and Abuse of Power in Medical Training

Nancy R. Angoff,

Office of Student Affairs and Department of Internal Medicine, Yale University School of Medicine, 367 Cedar Street, New Haven, CT 06510, USA

Laura Duncan,

University of California, San Francisco (UCSF) School of Medicine, San Francisco, California, USA

Nichole Roxas, and

University of Rochester School of Medicine and Dentistry, Rochester, New York, USA

Helena Hansen

Departments of Psychiatry and Anthropology, New York University, New York, New York, USA

Nathan Kline Institute for Psychiatry Research, Orangeburg, New York, USA

Abstract

Problem—Medical student mistreatment, as well as patient and staff mistreatment by all levels of medical trainees and faculty, is still prevalent in U.S. clinical training. Largely missing in interventions to reduce mistreatment is acknowledgement of the abuse of power produced by the hierarchical structure in which medicine is practiced.

Approach—Beginning in 2001, Yale School of Medicine has held annual “Power Day” workshops for third year medical students and advanced practice nursing students, to define and analyse power dynamics within the medical hierarchy and hidden curriculum using literature, guest speakers, and small groups. During rotations, medical students write narratives about the use of power witnessed in the wards. In response to student and small group leader feedback, workshop organizers have developed additional activities related to examining and changing the use of power in clinical teams.

Outcome—Emerging narrative themes included the potential impact of small acts and students feeling “mute” and “complicit” in morally distressing situations. Small groups provided safe spaces for advice, support, and professional identity formation. By 2005, students recognized residents that used power positively with Power Day awards and alumni served as keynote speakers on the use of power in medicine. By 2010, departments including OB/GYN, surgery, psychiatry, and paediatrics, had added weekly team Power Hour discussions.

Next Steps—The authors highlight barriers, benefits, and lessons learned. Barriers include the notion of clinical irrelevance and resistance to the word “power” due to perceived accusation of abuse. Benefits include promoting open dialogue about power, fostering inter-professional

collaboration, rewarding positive role modelling by residents and faculty, and creating a network of trainee empowerment and leadership. Furthermore, faculty have started to ask that issues of power be addressed in a more transparent way at their level of the hierarchy as well.

Keywords

Power; Medical training; Hierarchy; Medical education; Mistreatment; Inter-professional education

Introduction

Several studies illustrate the gravity of mistreatment of clinical trainees in the United States, citing prevalence rates ranging on average between 59 per cent to 76 per cent among medical students and residents (Cook et al. 2014; Fnais et al. 2014; Fried et al. 2012; Heru et al. 2009). Faculty, patients, fellow students, residents, and nurses contribute to an environment that conveys lack of respect for trainees and imparts feelings of low selfworth and powerlessness to trainees that are associated with burnout (Fried et al. 2012). Even more concerning, this environment may prevent positive intervention, inhibiting trainees from speaking up and, consequently, compromising the treatment and care of patients (Hafferty et al. 2015; Hafler et al. 2011; Hundert et al. 1996). Persistence of mistreatment of clinical trainees and, in turn, their patients, demands innovative thinking to combat a problem that is “part of the fabric of our institutional environments” (Sklar 2014, 694).

Previous interventions to disrupt the reproduction of mistreatment in clinical training have included value journals and discussion groups to try to restore empathy, combat burnout, and foster empowerment among individual trainees (Jennings 2009; Dunn et al. 2008). Yet, interventions such as courses on professionalism, medical humanities, ethics, or cultural competency that do not address the institutional forces and social pressures that lead to misuse of power leave intact the structures that foster abuse (Tsevat et al. 2015; Metzl and Hansen 2014). It is by directly examining power relationships and the positive and negative uses of power by members of the hierarchy that we may come to understand the internal structures of the practice of medicine that can lead to student mistreatment.

In the intervention described here, we use the concept of “power” rather than “abuse” to highlight the ways in which certain attitudes and behaviours of students are shaped. Unlike abuse, power can be used either negatively or positively. Since any person may have power over another in healthcare relationships, by understanding power and how it is used, students may themselves be empowered to take control and not succumb to the negative influences that may otherwise go unexamined when considering oneself a victim of abuse. In addition, rather than seeing power as simply as something individuals hold (Gabel 2012), in line with Donetto we encourage clinical educators to view “power as ... employed and exercised through a net-like organisation amongst the threads of which individuals operate” (2012, 1142). This view challenges the expectation that individual students alone should initiate transformative leadership and calls upon administrators to intervene at systemic levels. This systemic view of power corresponds to the concept of *structural violence*, based on the assertion that “violence is built into the (social/ institutional) structure and shows up as

unequal power” (Galtung 1969, 171). Here we consider the ways that medical training takes place within institutional and professional structures that can lead those in positions of authority to compromise the agency and dignity of trainees and patients.

There is evidence that institutional dynamics contribute to student mistreatment. The “hidden curriculum” of medical education, which has been well described by Hafferty, Hafler, and others (Hafferty et al. 2015; Hafler et al. 2011; Hundert et al. 1996), includes lessons that are implicitly conveyed to students via the values, behaviours, and attitudes of their surrounding community and is often described as leading to student mistreatment (Fried et al. 2012), a decrease in student empathy for patients, reduced excitement about medicine as a career, and a lack of positive role models (Crandall and Marion 2009; Kay 1990; Sheehan et al. 1990). Some students assert that good grades in professionalism come from uncritically following superiors’ orders, including those that are inappropriate and unprofessional, or covering up mistakes instead of espousing honesty and respect (Brainard and Brislen 2007).

Health professional schools especially struggle with aligning their purported educational goals of training competent and just clinicians with the hidden curriculum’s on-the-ground values that often privilege aggression, competition, and conflict (Wear 1997). Ultimately, we agree with Brainard and Brislen: “the chief barrier to medical professionalism education is unprofessional conduct by medical educators, which is protected by an established hierarchy of academic authority” (2007, 1010).

Medical students confirm power-hierarchy issues as common, with 50 per cent of third-year medical students’ narratives on the hidden curriculum focusing on power-hierarchy issues in training and patient care (Gaufberg et al. 2010). Students cite actions ranging from verbal intimidation to being ignored in clinic; these prove to be especially difficult to eradicate (Fried et al. 2012). Students struggle with being “silenced or bewildered,” feeling like they cannot respond to, and are therefore complicit in, misuses of power such as physicians using their authority to coerce patients into cooperating or mistreating trainees (Robins et al. 2002). Cassell states:

In the hospital, faculty members have jurisdiction over house staff, house staff have authority over students, and all these people are seen as authorities by patients.

There is probably no physician or medical student who has not seen or participated in callousness (or worse) in the treatment of patients in response to an order of a resident or an attending physician (2005, 328).

In light of these reports, interventions that seek to reduce negative uses of power and enhance responsible uses of power would need to go beyond an appeal to trainees to behave ethically; they will need to create an institutional environment in which ethical behaviour is supported.

Mainstream U.S. medical education has largely been silent on the topic of the systemic causes of power abuses between doctors and patients or medical school faculty and trainees. Medical curricula do not often examine the institutional origins of race, class, and gender inequalities in medical care, in health research funding, or in the definition of legitimate

medical concerns. Historically in the United States, patient advocacy movements originating outside of clinical institutions, such as the AIDS activist movement ACT UP, the Boston Women's Health Collective, and the breast cancer research lobby have forced clinical practitioners to consider systemic power inequalities by pressing for policy change and for the inclusion of representatives of disempowered groups in the decision-making of regulatory bodies and funding agencies such as the National Institutes of Health (Epstein 1996; Boston Women's Health Book Collective 1986; Epstein 2007). Educational approaches to rectify power inequalities, such as Paolo Freire's critical pedagogy (Freire 2006), have not been widely known or adopted among medical school faculty and administration. Given the lack of mainstream clinical literature and discourse about systemic power inequalities in healthcare, the conceptual frameworks and practical approaches for educational reform around power will necessarily come from outside of clinical medicine, drawing on narrative analysis from the medical humanities and on structural analysis from the social sciences including the anthropology and sociology of medicine (Tsevat et al. 2015; Kleinman and Benson 2006; Farmer 2003; Lewis 2011).

Approach

Inspired by 2000 international AIDS conference speaker Dr. Geeta Rao Gupta's explicit recognition of the role of power in controlling women's bodies, the Medical School Associate Dean for Student Affairs and a senior School of Nursing professor conceived a new intervention—"Power Day"—to promote positive uses of power in clinical training. The initial goal of the intervention was to elicit and examine students' stories of power dynamics as played out in medical relationships. This was designed not only to heighten the students' awareness of the pitfalls of the social roles related to status and codes of professional acculturation but also to heighten their awareness of themselves as agents for change within the professional culture of medicine. Other aims of the intervention are to involve medical school faculty in order to raise their level of understanding of students' experiences with power and to recognize and reinforce constructive uses of power by residents and faculty. This study was granted exemption from Yale University's Human Subjects Research review based on its conduct in an established educational setting, involving the normal educational practice of research on effectiveness of instructional techniques.

There are two Power Days. Power Day I activities are inter-professional, combining third year medical students about to begin clinical clerkships with advanced practice nursing students. This way, the composition of the learning community itself challenges the hierarchical divides between nurses and physicians, who are traditionally educated separately and between whom there is professional distance in clinical practice. Power Day I takes place early in the clinical training year of medical students and after a year of clinical training for the nursing students. This timing is to accommodate disparate schedules, but it effectively gives the nursing students an advantage in the conversation based on their additional experience and exposure to patient care. During their clinical year, which follows Power Day I, medical students are charged with being aware of power dynamics as they progress through their clinical rotations and with writing personal narratives which can then be discussed at Power Day II which takes place at the end of that year. Thus, Power Day I also serves as an "inoculation" for medical students to help them become aware of power

dynamics in clinical relationships and systems that may otherwise be glossed over, denied, or worse, accepted and adopted without pause or examination.

Power Day I learners participate in small group discussions facilitated by two faculty members: one from the nursing school and one from the medical school, thus fostering communication and collaboration at the faculty as well as student level. On Power Day II small groups are facilitated by a medical faculty member and an upper class student who went through Power Day II the previous year, thereby allowing students to gain a more sophisticated view of the issues and grow as teachers, facilitators, and leaders as they ascend the hierarchy. Power Day I discussion is grounded in stories from literature provided well in advance to all of the students. Literature has been shown to effectively teach students to analyse the medical profession (Moore-West et al. 1998). These discussion groups draw on narrative medicine approaches which use storytelling to encourage self-reflection and help practitioners progress in their professional development (Bolton 1999; Charon 2001a, 2001b; Scannell 2002; Verghese 2001). Power Day organizers chose literature as a safer, less emotionally threatening way of introducing the concept of power, its context, and its positive or negative uses compared with the use of personal stories. Moreover, because literature is not academic medical text, it invites perspectives outside of medicine into the conversation, furthering analysis of how power in medical settings interfaces with societal inequalities regarding race, gender, and socioeconomic status.

The pieces chosen invite readers to identify with both sides of the provider–patient relationship. To spark dialogue on racism, they assign Richard Selzer’s short story “Brute” that describes an overworked white doctor violently sewing the ears of an incarcerated black man so that he could close a laceration without protest. They also use Margaret Edson’s play *Wit*, in which the well-respected university professor protagonist analyses the ways in which her stage IV cancer diagnosis robs her of power by transforming her into a patient and forcing her to spar with a male-dominated medical hierarchy. Stories like these locate the sources of suffering not only in illness but also in the structure of medicine and society itself.

Power Day II discussion is grounded in the students’ own stories—de-identified narratives detailing their experiences in the wards or clinics in which they have witnessed the positive, constructive use of power and/or the negative, destructive use of power. Approximately ten are then chosen for circulation to spur small group discussion at the medical students’ Power Day II. After a keynote speaker, students break off into small groups of approximately ten moderated by two facilitators—a faculty member and a fourth year medical student—to confront the issues of power dynamics from the real life experiences of the students.

Methods

Data about Power Day has been collected in a variety of ways and used to refine and modify the day over the years since 2001. Most years, course directors meet with and debrief discussion group facilitators and collect students’ evaluations and suggestions on a voluntary course evaluation form. Suggestions that have been implemented as a result of this annual evaluation include adding awards for residents who demonstrate the positive and

constructive use of power and most recently adding awards for nurses as well. Changes in the literature used to stimulate discussion have also come out of these discussions and suggestions. For example, for several years in response to nurses who did not think that there were sufficient examples of negative uses of power among nurses, the book “One Flew Over the Cuckoo’s Nest” was used.

On one occasion, in 2003, immediately after the first Power Day II, social science graduate researchers experienced in interview techniques facilitated focus groups with student participants and faculty facilitators. These focus group researchers were not involved in implementing Power Day I or II, were independent of the medical school faculty, and guaranteed the anonymity of the focus group participants. Focus group leaders took detailed notes on the content of the discussions and completed thematic and content analysis of their transcripts. Feedback from these focus groups led to modifications in the design of Power Day II, including more attention to building a vocabulary and repertoire of responses for students to use in effectively responding to their superiors.

The narrative vignettes of positive and negative uses of power that students write for group discussion on Power Day II are also read and analysed annually by the course directors as a window into students’ training experiences and how they have changed over the years that Power Day has been implemented. For the analysis below, these vignettes were thematically coded and analysed by the authors of this paper. Discrepancies in coding between authors were discussed and resolved through discussion and consensus.

Outcomes

Student Narrative Analysis: Types of Power and Their Use

Table 1 summarizes our analysis of the narratives of power submitted by medical students from 2003 to the present. The three most common forms of power that students described related to (1) clinical supervisors showing what was worthy of attention; (2) reinforcing or challenging societal hierarchies and biases in clinical practice; and (3) the ways that oppression in the hierarchy of clinical staff led to aggressive behaviour among clinical team members.

Student’s narratives also described how these forms of power are exercised. For example, many indicated that the smallest gestures, little exercises of power—a supportive squeeze on the shoulder versus an impatient “Shut up” when a student raises a question—can have a huge impact. A second recurring description of how power is exercised was of silence—of students being rendered mute. Many describe witnessing an ethically distressing situation and not saying anything in the moment since they do not know how or what to say and later feel guilty about not speaking up. A student wrote, “I regretted my silence and attributed it to being at the bottom of a powerful hierarchy.”

Another way that negative use of power had an impact was through its impact on those, other than the student, who witnessed the interaction—including the patient. Clearly misbehaviour colours the learning environment for the trainee, but often the patient is affected both by the negative action and the resultant inability of the student or others to

intervene. After a difficult interaction with an attending physician, the student “sitting in the corner of the room continued to stare down at the floor but looked up long enough to see that the patient was staring down at the floor too.”

This last account speaks to another purpose of these narratives. An objective of Power Day is to create a safe space where students have a voice. Since supervisors evaluate students on their performance during clinical rotations, many fear speaking up in the face of power misuses due to a perceived risk of receiving negative evaluations. These anonymous narratives allow students to reflect and respond to both troubling and inspiring uses of power. The small group discussions complement this objective by providing an interactive peer space for students to receive validation, support, and advice, such as how to speak up when they notice a medical error or how to report a sexist interaction. Furthermore, the facilitators serve in a non-judgmental role that can help students reflect, analyse, and decide on appropriate actions. Some stories tell of students at risk of adopting negative behaviours modelled for them by people with more status than they have. A student quoted a resident as saying, “‘That little jerk in the ICU keeps trying to die, the little twerp.’ The students looked at each other, each with a raised brow, chuckled, and then returned their attention to the sign out.” Not clear from this story is whether the students chuckled because they thought the resident was inappropriate or because they agreed with her comments.

Finally, students can hold each other accountable as they brainstorm ways they can positively use power and be inspiring, knowledgeable teachers when they themselves are residents. Not all stories are of negative uses of power. For example, in one student’s story she admires a resident who stated that he “processed and filtered the information and proceeded to not just react but to actively choose” that he wanted to act “not from defensive mechanisms but from human compassion.”

Small Group Discussions of Narrative Vignettes: Student Dilemmas of Power

Beginning in the first year of Power Day II, when small student discussion groups were facilitated by faculty and residents to examine the written student narratives of power, we found that the group discussions prompted by student narratives often centred on the following four themes: (1) the power of the team; (2) students’ desire for solidarity with the patient and team; (3) the power of caregiving to vulnerable people; and (4) the impact of modelling positive uses of power.

Power of the Team

One of the vignettes most frequently discussed by the groups on Power Day II described the humiliation of a third year student who aspired to a competitive surgical subspecialty. During a key surgery clerkship his residents refused to help him work up his patients, leaving him inadequately prepared for his departmental case presentation. When he reported this situation to the chief resident, he was berated in front of all the residents for blaming others and not being a team player. The student was left feeling discouraged, disappointed, and humiliated.

The Group discussions focused on the power that residents and attendings hold over students because of their ability to influence evaluations and thus residency choices. Anxiety about

these evaluations keeps students from speaking up when disrespected or when asked to go against their principles. The students believed that clerkship evaluations were critical in their career and believed them to be arbitrarily awarded amongst students extraordinarily vulnerable to the influence of their superiors. Following the group discussions, students called on medical school administrators to improve the clerkship evaluation system and generated a list of suggestions to help address the vulnerability they experience in their power relationships with residents and attendings. The list included establishing clearer expectations for students, requiring and documenting more contact with, and continual performance feedback from, faculty, and creating a system for ensuring the anonymity of feedback given by students to the office of education about faculty and housestaff.

Power of the Patient: Students' Desire for Solidarity

Another much-discussed vignette told of a patient who inquired about a student's nationality while the student's team completed rounds. The student responded that she was Korean, and "figured he, like many other male patients his age, just wanted to let me know that he had fought in the war and such." The patient, however, responded by stating,

"That's what I thought! You know what? When I was in Korea, I killed hundreds, *thousands*, of you guys!" And went on to describe, with a snicker on his face, the time he "picked up my machine gun and shot a Korean officer straight across his stomach, back and forth. And I cut him in half!"

The student wrote that she

stood there, stunned. I looked to the rest of my team and they all looked equally stunned. I was like a deer caught in headlights. I couldn't move, I couldn't say a word, and I couldn't avoid his eyes. As the tears began to well up in my eyes, I looked at my team for something, anything. Yet not a peep came from the chief resident, not from the second year residents, not from the intern, and not from my fellow classmate. After a few minutes of uncomfortable silence, our chief finally said, "You're a veteran? I didn't know you're a veteran!" as if he had not even heard that entire conversation.

This student experienced a feeling of powerlessness compounded by her feeling of isolation. She expected her teachers and co-workers to defend her from the patient's disrespect and aggression. The silence of her team reinforced an implicit normative message that she did not have the right to defend herself from the patient. The student's desire for solidarity, and her disappointment at the lack of empathy and support from her team, was echoed by other students in group discussion. Where were the role models? Indeed, in the groups of Power Day II this vignette led students to tell stories of feeling powerless to stop mistreatment on the wards, whether it was "a fellow student acting inappropriately," or when students were used as "whipping boys" by residents and attendings. The groups also discussed what to do when the team abuses a patient or a student.

Many focus group participants said that these discussions showed them that they were not alone, noting that it was helpful to hear other people's strategies for dealing with problems. They thought that their discussion reinforced the need for students to support each other, and

they were encouraged that the faculty members who heard their stories “were just as outraged as we were,” stating—“It is nice to know that the administration cares.”

Power of Caregivers

Another widely discussed vignette described the students’ discomfort with the treatment of a patient whose vulnerability he sensed and saw ignored. One student described a patient who was a very young, frightened Spanish-speaking woman with pelvic pain. The patient had been told to get on the examining table and her feet were placed in the stirrups. The student reported that he

sat at her left shoulder holding her hand and trying to soothe her, but I could feel her shaking. The attending doctor pushed open the door and without saying a word to anyone but the resident, he proceeded with the pelvic exam, turning to the resident to explain what he was feeling. The patient started crying. I stood up and said, “Dr. S, I’d like to introduce you to your patient.”

In this story the student actually tried to take control over the situation by standing up and insisting on at least social amenities that may have helped comfort his patient. But the fact that no one on the team spoke Spanish or attempted to get an interpreter before starting the examination, led some students in the focus group to comment that the discussion should be put in a broader perspective, taking into account how politics, economics, and insurance coverage related to inequalities in medical care. Others, however, appeared overwhelmed by what appeared to be healthcare system-wide issues and offered few ideas about how any of this could be effectively addressed. Students, for example, did not feel that formal structures, such as telling and enlisting the help of those in power, would be worthwhile. Many students agreed that “the emphasis on channels of reporting of abuse on the wards is not helpful ... (we need) practical means of dealing with the situation.” In addition, some felt that these Power Day discussions only reinforced their feelings of powerlessness because no new solutions surfaced, and “it makes us more nervous about restarting on the wards.” As one student said, “I don’t feel more empowered from the day. I feel like I need to suck it up and deal with things.” Indeed, focus group participants consistently asked for practical, concrete suggestions for addressing abuses of power on the wards. Many felt that being asked to reflect on the injustice of their working conditions, without being given stories of success or tangible skills to cope with them, only heightened their insecurity.

Modelling Positive Uses of Power

One widely discussed vignette about the positive use of power described

the most amazing physician I have ever had the privilege of watching interact with patients. She enters the room with a smile; she touches her patients’ hands when they need to be comforted. She even sits on their beds when they are too weak to speak loudly or when we visited a patient who was weak, blind, and hungry. Breakfast was already on the tray table but was untouched. The patient loved pancakes, but said his wife usually “helps me out.” So, without a moments’ hesitation, the attending picked up his knife and fork and cut his pancakes with the care one would show her own child.

The student noted that

the whole event took about five minutes—the time we could have spent presenting the next patient. But no one on the team complained—it seemed so natural. Of course our attending would cut up a blind patient’s pancakes! I remember thinking that I wanted her to be my doctor, and she is the doctor I myself want to become.

In their discussions, students expressed conviction that patients were to be respected and that patients’ interests were to be the centre of medical decisionmaking. They looked up to attendings and residents who conformed to this ideal.

On rare occasions, students reported that they were able to “stand up to their superiors” when focused on the needs of the patient. For instance, one student was able to tell his attending that a patient had been upset by the attending’s excessively rough exam of her abdominal incision. But most students were unable to speak up on behalf of patients and had even more difficulty finding a way to stand up for themselves, either when they felt disrespected or when they were concerned about the quality of their education. Students doubted whether their right to appropriate treatment was seen as legitimate in the institutional climate of the teaching hospital. They also reported wanting more attention to their education, but few felt they could approach those in authority, such as their residents and attendings on the wards, when their education was neglected.

Changing the Clinical Culture of Power: Power Day Awards and Power Hours

In 2005, the second component of Power Day II was introduced: Power Day awards. As a result of their discussion groups and narrative writing about power, students asked to officially recognize residents who model positive uses of power. Indeed, students identify role modelling as an important part of the hidden curriculum (Gaufberg et al. 2010). Prior studies have shown how influential professionalism role modelling is in the teaching of medicine and a study examining interventions into medical student mistreatment listed a lack of positive modelling by faculty and residents as a reason why mistreatment was so persistent in the face of multiple attempts to combat it (Karnieli-Miller et al. 2010). Power Day awards were created to send the message that clinicians who choose to empower others, especially students and patients, are to be rewarded and imitated. What began as only two resident awardees has expanded to include residents from every clinical department. Department chairs and residency directors are invited to Power Day to hear the stories of the residents who receive the awards, and Power Day awards have acquired respect, prestige, and legitimacy among students, residents, and the hospital community as well. Over the years, many of the Power Day keynote speakers have been Yale Medical School alumni invited back to discuss how they have developed a critical analysis of power and used it in empowering ways.

Individual departments at Yale have adopted the principles of Power Day and put them into practice. Paediatrics and OB/GYN hold weekly meetings, called “Power Hours,” that include students in open conversations about power within their units. Psychiatry does the same but calls it “Empower Hour.” In this way, confrontation of the role of power in the hierarchical structure of medical practice is being incorporated into the fabric of our

institution, positively shaping the hidden curriculum for future healthcare professionals and students.

Next Steps

Power Day interventions have had a number of beneficial effects on our training program and professional culture, in that students report feeling less alone in dealing with uncomfortable situations on the wards, and the use of power in healthcare relationships has become a more open and legitimate topic of discussion. Faculty members are more aware of the dilemmas in which students and residents find themselves and are expressing concern about their own role in modelling the responsible use of power. Many have taken the initiative to hold regular discussions of the use of power in their departments. We have encountered barriers in implementing Power Day, however. The first was student scepticism regarding its relevance. When Power Day was first introduced, it was seen as another arbitrary addition to the curriculum that focused on analysis instead of action. They questioned the importance of critically analysing power and social hierarchies, echoing the sentiments of students in other institutions to whom social and cultural awareness curricula have been introduced (Beagan 2003). In addition, in the first two years of Power Day, some students said they felt more anxious and less empowered by discussion of vignettes of abuse of power, particularly those vignettes that involved broader institutional, political, and economic forces that were seemingly beyond the control of individual students. Over time, however, students have begun to ask for Power Day and in one year when it was delayed, several students emailed to say they hoped it would take place. More recently at meetings, faculty have raised the question of whether they should be discussing power in an open and transparent way as the students do, and there have been calls for ensuring that newly hired leaders such as chairs of departments be assessed for their ability to manage power well.

Another important limitation is time, with only two half-day workshops trying to reinforce values that are often different from the on-the-ground values of a medical school curriculum that is biomedically oriented and in which social approaches are seen as secondary at best. The fact that faculty members have initiated discussions of power in their departments has begun to address this limitation.

Some faculty and administration have been wary of using the word “power” for its assumed focus on power abuse. The Surgery Department holds a weekly session for students to confront in real time situations that they find troublesome but unlike paediatrics, obstetrics and gynaecology and psychiatry, does not name it Power Hour. “Professionalism” Day was offered as a less controversial alternative; yet, professionalism is already integrated into the curriculum and focuses on individual skill whereas Power Day holds all members of the clinical social structure accountable. To address their scepticism, we actively invited faculty and administrators to participate as facilitators, award witnesses, or audience members.

Structural change is slow. The educational mission of the School of Medicine is to educate and inspire leaders. Leadership requires attention to the use of power. Our vision is to educate leaders who permeate the culture of medical practice both locally and at a distance where they will infiltrate the institutional structures. To date we have heard from several of

our former students and Power Day award winners who wish to replicate the program at their new institutions.

Thirteen years after its inauguration, Power Day is one of “100 Reasons” to choose Yale University’s School of Medicine mentioned in its admissions brochure. Not only does it make power relations visible, it also offers solutions to real life clinical dilemmas through peer support and facilitated small group discussion. It introduces positive power role modelling for trainees in their professional identity formation. Current resident recipients of the Power Day awards are officially recognized and rewarded as positive role models who use power to propel the goal of patientcentred care forward by their example, becoming sources of pride for their departments and are often celebrated at departmental events. Bringing back Power Day graduates as speakers provides a network of clinicians interested in engaging with questions of power and models how to continue constructive engagement with it throughout their careers . Power Day provides an opportunity for inter-professional collaboration and positive role modelling so that the students themselves do not perpetuate the cycle of disempowerment and mistreatment, but rather become positive power role models engaged in altering the structure and culture in which they are trained and in which care is delivered.

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Table 1

Examples of positive and negative exercise of power from medical student narratives written for Power Days 2003—present

Type of Power	Student Quotes Illustrating Positive and Negative Uses
Showing what is worthy of attention	<p>(-): “[The attending] caused the patient a good deal of pain and had done it without warning her.”</p> <p>(-): “The patient was trying to get our attention. Our attending had already moved on. The resident looked up from the chart, rolled his eyes, and let out a pissed-off sigh. He looked at me and the other med student. [...] I ran to bring her a basin. ... We rejoined the team, now two doors down. They didn’t ask why Ms. B had called us.”</p> <p>(-): There is a “normalcy to never having a conversation with the attending,” and the “attending not knowing the names of medical students throughout the entire rotation.”</p> <p>(+): A patient died after a code. “The patient’s wife of fifty years came into the charting room crying. ... Even though we weren’t involved in the patient’s care, the intern on my team embraced her and said, ‘I’m sorry I couldn’t do more.’ I learned that a few choice words could be very powerful.”</p> <p>(+): An intern “threw all hierarchy out the window when it came to appropriate patient care ... my intern knew immediately his responsibilities to his patient and her safety came first and he used his power of decision to do what was right for the patient, despite it costing him a few scornful looks.”</p>
Reinforcing or challenging societal hierarchies and biases in clinical practice	<p>(-): A patient tells a Korean medical student about how he killed Koreans during the war in front of her team, but “At the very least... I wish someone would have just asked me how I felt or offered to talk—anything to make me feel less like I have overreacted or was being overly emotional. As it was, however, I couldn’t help feeling somehow betrayed by my own team.”</p> <p>(-): An attending’s advice to a female medical student: “You need to be more aggressive, or else ... you’ll just be a quiet, albeit bright, lady doctor with some kids.”</p> <p>(-): “The differential between different socio-economic classes and quality of care overall was stark ... the resident spoke [to a low income patient] in a frankly disrespectful and abrasive tone, telling the patient something to the effect that she didn’t know how to push properly and unnecessarily and unprofessionally displaying her own exasperation at this patient’s difficulty. ... One of the scrub nurses exclaimed—I believe this was just after the patient was wheeled out of the OR—‘does she not speak English or is she just stupid?’”</p> <p>(+): Without a moment’s hesitation, the [attending] picked up [patient’s] knife and fork and cut his pancakes with the care one would show her own child. [...] The whole event took about five minutes—the time we could have spent presenting the next patient. No one on the team complained—it seemed so natural. Of course our attending would cut up a blind patient’s pancakes! I remember thinking that I wanted Dr. F to be my doctor; she is the doctor I myself want to become.”</p> <p>(+): “I felt that it was a tremendously positive use of power to recognize individual custodial staff members and the important work they do to keep the hospital clean and in order. The impact of Dr. B’s authority [transplant surgeon attending] in this case was to make individuals who are often overlooked feel as though they’re a valued part of the hospital staff.”</p> <p>(+): A transplant surgeon asks “about their medications, their kidneys, their wounds, but she is equally interested in their mental health, their fitness, their nutrition—the entirety of their lives ... she says that she just treats her patients how she would like to be treated if she were the patient... She prefaces her responses to even the most basic question with an encouraging “that’s a great question” ... she speaks of procurement, not harvest, because “it is not about picking crops” ... she recreated my image of a surgeon. I say, “This is the foot.” She looks at me and rests a hand on my shoulder. “No,” she says gently and sighs, “This is the <i>man</i> with the foot.”</p>
“Oppression breeds aggression”	<p>(-): A medical student is told by a nurse to eat lunch outside while the attending and fellow eat big, messy lunch inside and the nurse says nothing.</p> <p>(-): Medical students feel trapped in “the strict hierarchy of the team, and the fear that many members seem to harbour of their various superiors. ... Is [this] the most effective way for us to ultimately fulfil our responsibilities to provide the best possible care for patients?”</p> <p>(-): A medical student put a pillow over a patient’s genitalia after the drapes were drawn</p>

Type of Power	Student Quotes Illustrating Positive and Negative Uses
	but a nurse grabbed pillow out of hands: 'I know they teach you at the med school that crap about covering your patient and respecting them and all but you already had the curtains drawn, you don't need to use the pillow—we're all adults here.' I couldn't believe that I was being disrespected because I was being too conscious of a patient's dignity. ... (I) realized that in order to respect the patient those taking care of the patient need to respect each other."

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