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WHEN “FIRST, DO NO HARM” FAILS:
A RESTORATIVE JUSTICE APPROACH TO WORKGROUP HARMS IN HEALTHCARE

by

Pedro L. Flores

A dissertation submitted in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy

May 2022

Dissertation Committee

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TITLE OF DISSERTATION: WHEN "FIRST, DO NO HARM" FAILS: A RESTORATIVE
 JUSTICE APPROACH TO WORKGROUP HARMS IN
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ABSTRACT

In healthcare, workgroup mistreatment is a pervasive problem that begins during medical education (medical and nursing school) and becomes embedded in the “hidden curriculum of professionalism,” which dissuades and even punishes learners for talking about abuse they witness. Furthermore, the mistreatment of healthcare providers (HCPs) pervades all disciplines in the healthcare delivery chain due to a combination of cultural factors, systemic pressures, dysfunctional hierarchies, and leadership’s tolerance of intimidating and disruptive behaviors. Not surprisingly, 18% of U.S. HCPs have left the medical field since the start of the COVID-19 pandemic, and burnout, stress, anxiety, and increased workloads have been identified as predictors of intent to leave the health professions. To address the mass exodus of HCPs, it will be necessary not only to train emerging providers in a way that changes the culture, but also to address attrition in the current healthcare workforce.

This three-stage, exploratory sequential mixed methods research study merged the health and social sciences by piloting restorative justice (RJ) practices in healthcare settings. First, through conducting semi-structured interviews of 12 HCPs, the deleterious impact of workgroup mistreatment was thoroughly explored and interpreted using a restorative framework. Next, through piloting two RJ interventions in academic medicine and academic nursing settings, respectively ($n = 333$), the feasibility of implementing RJ in healthcare was determined. Finally, through evaluating the RJ interventions via multivariate survey ($n = 87$), statistical outcome data quantified the benefits of using an RJ approach to address climate concerns in healthcare.

What emerged was a clear imperative to use RJ in healthcare settings to ameliorate the impact mistreatment has on HCPs’ mental health, job satisfaction, and quality of communication and teamwork. Furthermore, quantitative data indicate early adoption success of using RJ to (a)

help build and strengthen relationships, (b) foster a sense of belonging, (c) improve the climate, (d) improve teamwork, and (e) improve work intentions. Thus, a new leadership paradigm, the Restorative Accountability in Healthcare Model (RAHM) is proposed. These findings have clinical, administrative, and policy implications for healthcare leaders, healthcare systems, medical learning institutions, and for preceptors and clinicians more broadly.

Keywords: restorative justice, leadership, healthcare, culture, workgroup mistreatment

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CHAPTER ONE

INTRODUCTION TO THE STUDY

In healthcare, workgroup mistreatment is a pervasive problem that begins in medical and nursing school and becomes embedded in the “hidden curriculum of professionalism,” which dissuades and even punishes learners for talking about abuse they witness (Major, 2014). Thus, 42% of medical students reported being mistreated at some point during medical school (AAMC, 2019). Worse still, 78% of nursing students reported bullying while in nursing school (Hulya et al., 2017). Although the existing literature has focused primarily on the impact mistreatment has had on physicians, nurses, and medical students, workgroup mistreatment pervades all disciplines in the healthcare delivery chain due to a combination of cultural factors, systemic pressures, and dysfunctional hierarchies. The history of tolerance and indifference to intimidating and disruptive behaviors in healthcare is a leadership problem with far-reaching consequences (Porto and Lauve, 2006). According to The Joint Commission (2008), disruptive behaviors in healthcare environments lead to poor performance in teamwork, decreased job satisfaction, and ultimately decreased quality of patient care.

To better understand the issues that contribute to these harms occurring in healthcare, it is important to discuss the pressures being placed on the healthcare providers (HCPs) at this point in time. The U.S. healthcare system has undergone tremendous challenges in the past 10 years, especially since the passage of the Affordable Care Act (ACA) in 2010 and its implementation in 2014. Expanding healthcare coverage to an additional 20 million Americans through the ACA (Obamacare), a decision which is still widely debated, created additional strains on an already embattled system known for producing poor outcomes despite leading the world in expenditures (17.7% of GDP in 2018) (CMS, 2019). Concurrent reforms by Medicare and the U.S.

Department of Health and Human Services (HHS) to improve healthcare quality, reduce costs, and improve clinical outcomes have forced many healthcare organizations to find new ways of improving the delivery of care. The SARS COVID-19 pandemic, an airborne viral respiratory disease which has claimed the lives of nearly one million Americans and infected over 79 million others thus far (CDC, 2022), has further highlighted the inefficiencies of the U.S. healthcare system and exacerbated longstanding healthcare disparities (CDC, 2020).

According to the Bureau of Labor Statistics (2021), approximately 18% of the U.S. healthcare workers have left medicine since the COVID-19 pandemic began. Among those exiting acute care settings specifically, registered nurse (RN) turnover increased by 8.4% in 2021 and currently stands at 27.1% nationally (NSI, 2022). Furthermore, Sinsky et al. (2021) revealed that COVID-19–related anxiety/depression, burnout, stress, and workloads were predictors of intent to leave the health professions. Approximately 30% of physicians, nurses, and advanced practice providers (APPs) surveyed in 2020 intended on reducing their work hours within 12 months. Worse still, 23% of physicians, 40% of nurses, and 33% of APPs intended on leaving their practice within 2 years. To address the looming exodus of healthcare workers, it will be necessary not only to train emerging HCPs in a way that changes the culture, but also to address burnout and attrition in the current healthcare workforce.

The cumulative effects of expanding coverage, improving quality while simultaneously reducing costs—coupled with an ongoing, intractable public health crisis—places healthcare under intense public scrutiny. The forces at play in the political, regulatory and economic spheres, just to name a few, influence the way healthcare institutions organize and deliver services. These decisions, in turn, directly affect organizational culture and the systemic pressures (structures) placed on HCPs. For example, the shortage of personal protective

equipment (PPE) and mechanical ventilators coupled with grossly understaffed hospitals brought into sharp focus the downward pressure applied to frontline healthcare workers early in the COVID-19 pandemic. As our polarized nation continues to grapple with issues of racial injustice, healthcare inequities, the economy, and a mass exodus of HCPs, healthcare and its limitations will continue to occupy the national spotlight.

Adapting to the aforementioned pressures presents several moral, ethical and practical challenges. For any healthcare organization, leadership's first priority is to be accountable for effective care while protecting the safety of patients, employees, and visitors (The Joint Commission, 2017). However, when you consider healthcare's patriarchal foundation (Carlson, 2019), embedded clinical hierarchies, demanding workloads, and high-stakes clinical situations—it is no surprise both healthcare consumers and providers end up being harmed by the system. For the patient, this can manifest as a lack of access to quality healthcare (being uninsured/underinsured) or through medical malpractice/medical error. For the HCP, this can occur through workgroup mistreatment such as verbal abuse, violence, harassment, intimidation, and bullying (Porto & Lauve, 2006; OSHA, 2015; The Joint Commission, 2016). Therefore, this study will explore the nature and impact of workgroup mistreatment experienced by HCPs, medical students, and nursing students, as perceived by them.

Harms in Healthcare

Although HCPs go through extensive training centered on protecting their patients' safety, including the Hippocratic oath to "first, do no harm," sadly, harm still occurs in healthcare. I define healthcare harms in three broad categories (1) unjust equity harm, (2) malpractice harm, and (3) mistreatment harm.

Unjust equity harm refers to harms that result from the lack of access to quality healthcare among socially disadvantaged groups. As a result, some populations develop health disparities, which are health differences that adversely affect socially disadvantaged groups, and are systematic, plausibly avoidable health differences according to race/ethnicity, skin color, religion, nationality, socioeconomic resources or position, gender, sexual orientation, gender identity, age, geography, disability, illness, political or other affiliation, or other characteristics associated with discrimination or marginalization (Braveman, et al., 2011). Some populations that typify this include prisoners, the uninsured/underinsured, people of color, populations that have been exposed to environmental health hazards, and even subjects of racially unjust research. As a result, these vulnerable populations are harmed by the lack of access to social determinants of health and/or by developing preventable diseases or chronic illnesses at disproportionate rates relative to the general population at the macrosystem level.

Malpractice harm refers to the physical and/or emotional harm that results from medical malpractice and/or a medical error. Medical malpractice occurs when a hospital, doctor or other health care professional, through a negligent act or omission, causes an injury to a patient. The negligence might be the result of errors in diagnosis, treatment, aftercare or health management (ABPLA, 2020). Some examples of this type of harm include gross negligence manslaughter, performing surgery on the wrong limb, or systemic errors like improperly dosing and administering a medication. As a result of medical negligence and systemic errors, these individuals (patients and/or their families) are harmed while under the care of a healthcare organization at the mesosystem level.

Lastly, *mistreatment harm* in healthcare refers to the physical and/or emotional harm that occurs between HCPs, or between HCPs and patients as a result of unhealthy relational

dynamics. This study will be limited to the workgroup relational harms that occur between colleagues. According to Major (2014), “attending physicians, residents, nurses, and students define abuse differently, with further variability based on specialty, gender, and ethnicity” (p.156). For this study, workgroup mistreatment is defined as unpleasant behavior that can cause ill effect or danger, including but not limited to physical assault, verbal abuse, coercion, harassment, bullying, and intimidation. As a result of workgroup mistreatment, these individuals (HCPs and learners) experience harm at the microsystem-level.

Restorative Justice

Restorative justice (RJ) is both a philosophy and procedural framework for redressing harm and conflict. According to Zehr (2015), “RJ is an approach to achieving justice that involves, to the extent possible, those who have a stake in a specific offense or harm to collectively identify and address harms, needs, and obligations in order to heal and put things as right as possible” (p. 48). Restorative practices (RP) are a set of facilitator-led procedures, such as circle processes and conferences, that can be used to convene groups of people with a shared stake in a harm, offense or community concern. Fundamental to the success of RJ is involving key community members in a collaborative process of storytelling, accountability and decision-making. As a result, RJ has a high rate of “victim/offender” satisfaction because people who have caused harm (1) accept and acknowledge responsibility for their offenses, (2) to the best of their ability repair the harm they caused to harmed parties and communities, and (3) work to reduce the risk of repeating their offense by building positive social ties and facilitating systems learning (Acosta & Karp, 2018).

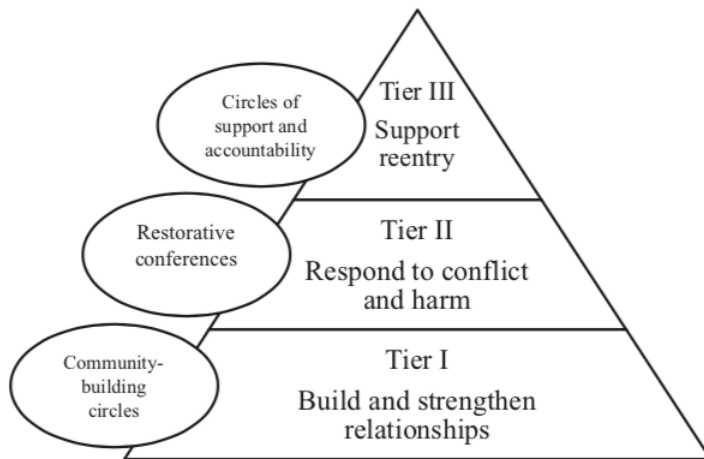
The historical underpinnings of RJ, which include First Nation circle practices and the New Zealand Maori conference practices, have endured in spite of a shift toward modern,

punitive approaches to redressing harm and misconduct. Viewed as an ethical framework rather than a procedural model, RJ is distinguished by its commitment to building positive, just and equitable relationships (Karp, 2019). Although its resurgence is seen as a *global social movement*, which is gaining traction in various sectors, iterations of modern-day RJ have been around for centuries. However, its contemporary application emerged in the 1970s in the criminal justice setting in Canada. To date, RJ has been successfully used in criminal justice, K-12, juvenile justice, and higher education settings, however, it is just beginning to be explored in healthcare, academic medicine, and academic nursing (Acosta and Karp, 2018; Carroll & Reiser, 2018).

RJ's three-tier design, its procedural continuum, which is depicted in Figure 1 (Acosta & Karp, 2018), makes it transferable to the healthcare setting since it can be used to build and strengthen relationships, manage workplace climate issues, address individual incidents of harm/misconduct, and facilitate workplace reintegration. For example, Tier I practices, including community-building circles, are used to develop interpersonal communication skills and mutual understanding across key stakeholders. Tier II practices, including restorative conferences and climate circles, allow stakeholders to respond to individual or communal incidents of harm or misconduct. Climate circles, in particular, can be used to provide inclusive dialogue, healing, accountability, and action plans (Karp, 2019). Finally, Tier III practices, including circles of support and accountability (COSAs), are used to ameliorate difficult community reintegration processes for people who have caused harm (Acosta & Karp, 2018).

Figure 1

RJ Procedural Continuum



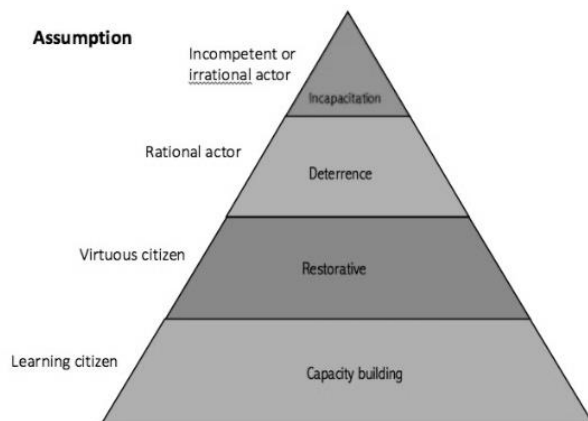
Note. (Acosta & Karp, 2018)

Braithwaite's Regulatory Pyramid

Although there are intuitive benefits to conceptualizing RJ as a three-tiered procedural framework, John Braithwaite, an Australian RJ pioneer, professor and theorist, further defines RJ as a *responsive regulation* strategy. According to the assumptions of his theory, which is depicted in Braithwaite's Regulatory Pyramid (see Figure 2), RJ is just one strategy in a hierarchy of strategies for regulating a problem of concern (Braithwaite, 2016). RJ, which is situated at the second tier of the pyramid, approaches a problem (e.g., misconduct in healthcare) from the standpoint that relationships can be used as a less coercive form of justice (Braithwaite, 2016).

Figure 2

Braithwaite's Regulatory Pyramid



Note. (Braithwaite, 2016)

Thus, by maximizing the capacity of stakeholders who have been empowered to address a communal problem or individual offense, RJ has the capacity to resolve the problem by appealing to the responsible party's morality, through integrating shame, and to a lesser extent their rationality, rather than using sanctions or other punitive strategies like incapacitation (Braithwaite, 2016). Another presumption of the pyramid is that persuading a capable, "virtuous actor," someone who is willing to accept responsibility for the harm they have caused, gives the cheaper, more respectful option a chance to work first (Braithwaite, 2016).

Therefore, Braithwaite's regulatory pyramid will be the conceptual framework guiding this research study. By using restorative circles, the voices of those who have been harmed by other HCPs will be amplified, and the resulting case studies will explore the benefits, if any, of using RJ to redress harms in healthcare, academic medicine, and academic nursing. However, it is important to acknowledge that embarking on a highly dialogic, relational enterprise is antithetical to the transactional, fast-paced nature of healthcare which is extremely hierarchical, favors specialization over collaboration, and whose workforce is severely limited by time constraints (Zulman et al., 2020). Finally, HCPs may be skeptical about sharing their experiences with workgroup mistreatment because hospital administrators have largely tolerated physicians' verbal abuse and disruptive behaviors (Holloway & Kusy, 2010).

Problem Statement

There is a history of tolerance and indifference to intimidating and disruptive behaviors in healthcare and medical learning environments (Porto and Lauve, 2006), which is not just limited to physicians and nurses. According to the Institute for Safe Medication Practices (2003), these behaviors occur among pharmacists, therapists, and support staff, as well as among

administrators. Failure of leadership and current HR response systems to address issues of misconduct, such as verbal abuse, harassment, intimidation, and bullying (to name a few) and failure to address the community fall-out related to issues of misconduct has far reaching consequences. Not only does silence lend itself to repeat offenses that lead to endemic practices, but it contributes to a culture that undermines safety and indirectly promotes unprofessional behavior.

Thus, healthcare leaders are left to contend with several moral and practical dilemmas about how to: (a) continue to provide high quality, compassionate healthcare, (b) safeguard their employees from harms related to workgroup misconduct, (c) limit the impact disruptive behaviors have on teamwork and patient care outcomes, (d) improve job satisfaction rates for the sake of retaining valuable employees, and (e) educate healthcare students in ways that eventually change the culture. Given RJ is just beginning to be explored as a way of ameliorating workgroup mistreatment harms in healthcare, there is a need for empirical research that not only qualifies certain assumptions about the impact workgroup harm has on HCPs, but more importantly, the positive impact a RJ intervention has, if any, on ameliorating those harms.

Purpose of the Study

The purpose of the study is to explore the nature of workgroup mistreatment experienced by HCPs, medical students and student nurses, as perceived by them. Specifically, the study will fill a void in the literature by providing knowledge on the types of harms experienced by HCPs in the clinical setting (acute care), exploring the impact these harms have on individuals and teams, and determining what role the institution plays, if any, in allowing these harms to occur. Additionally, the study seeks to better how healthcare leaders and HR teams respond to workgroup mistreatment and climate concerns, and how these experiences affect harmed parties'

work intentions. Lastly, the study will seek to determine in which ways, if any, do HCPs, medical students and nursing students benefit from RJ interventions.

Because little is known about the ways in which HCPs and medical students deal with workgroup mistreatment, this study will generate a thematic analysis, using the restorative inquiry framework, which will be used to confirm or augment existing theory. The qualitative data will also be used to create several RJ interventions (e.g., community-building circles, climate circles), then a multivariate survey, which will be used to evaluate the effectiveness of those RJ interventions.

Research Questions

The following research questions will guide the study, at least initially. From the perspective of the healthcare provider, medical student, or nursing student:

1. What types of workgroup-related harms do HCPs, student learners, and healthcare teams experience in the acute-care setting?
2. What impact does workgroup mistreatment have on HCPs, student learners, and healthcare teams?
3. In what ways, if any, are healthcare organizations and/or academic institutions responding to workgroup-related harms?
4. In what ways, if any, do HCPs and/or learners benefit from restorative practices to deal with workgroup-related harms?
5. What leadership implications do healthcare/academic medicine leaders contend with when implementing RJ at their respective institutions?

CHAPTER TWO

LITERATURE REVIEW

The purpose of this chapter is to evaluate the corpus of the literature surrounding the use of restorative justice (RJ) / restorative practices (RP) in the healthcare setting. Since restorative practices are not yet routinely used in healthcare, a holistic approach to unveiling the extant research on RJ in healthcare included searching academic, multidisciplinary, subject-specific and journal databases. The databases prioritized for this literature review included Cochrane Database of Systematic Reviews, JSTOR, SAGE Journals, Springer Nature and Wiley Interscience. The peer-reviewed journals prioritized for this review were Healthcare and Nursing. In addition, the search process included interviewing subject matter experts, listening to webinars, reading books, and searching the internet for local/international journal articles and dissertations that may have eluded the databases. The search terms used included: restorative justice (RJ) or restorative practices or restorative approach and healthcare or health care or health service or medical care.

The initial impression is that very little empirical research has been done on the use of RJ in the healthcare setting. In fact, most of the literature was found to be non-experimental, anecdotal case studies, or position papers advocating for the transferability of restorative practices into the healthcare sector. However, it is important to note that none of the literature prospectively evaluated the effect restorative practices had on redressing coworker-related harms in healthcare explicitly. Because of the limited amount of empirical research available on this topic, this literature review is biased toward depth rather than breadth, beginning with a delineation of the types of harms that occur in healthcare and academic medicine. This distinction is important because to get a better understanding of how restorative practices can be

used to redress harms in healthcare and medical learning settings, harm must be explicitly defined and analyzed at various levels. I define healthcare harms in three categories (1) unjust equity harm, (2) malpractice harm, and (3) mistreatment harm.

RJ and Unjust Equity Harm

In the health equity space, Harris et al. (2014) identified RJ as a way of addressing health disparities and improving the right to access healthcare in a post-apartheid context in South Africa. Specifically, they looked at interpersonal engagement with HCPs, labeled street-level bureaucrats, to gauge a health system in transition from a repressive state towards a justice state (Harris et al., 2014). Using a case-study analysis of eight participants who experienced access barriers to healthcare, the authors nest RJ under a broader sociopolitical endeavor of *restorative health*, which is defined as the idea that those who have been denied access to the social determinants of health, particularly as young children, should have the right to restoration of healthy functioning (Henderson & Jackson, 2004). The authors caution that RJ and restorative health are not interchangeable terms, however, they state, “RJ may partially restore health, while restorative health has the potential to improve interpersonal practices and bring justice to relationships” (Harris, et al., 2014).

The authors attribute the “structural violence” of apartheid, which is systemized and entrenched injustice, as the cause of massive and avoidable inequalities and power differentials between communities and population groups, reflected in highly inequitable health outcomes between races and places (Galtung, 2006). Harris et al. (2014) highlight the use of the restorative practice victim offender mediation (VOM), which was successfully used in the case of Harry Nyathela, an AIDS activist who was incarcerated and denied access to antiretroviral therapy.

VOM entails a carefully facilitated process with victims, offenders and support persons and is an applied method for resolving certain types of interpersonal conflict (Harris et al., 2014).

However, their research speaks less to the process of strategically implementing RJ into the post-apartheid health context in exchange for revealing the variables that position HCPs in the middle of the structures, institutions, and relationships that mediate society (Harris et al., 2014). By acknowledging the role HCPs play, as “agents of social control,” exerting either positive or negative interpersonal exchanges with patients, they propose that RJ offers an avenue into assessing the feasibility and scope of interpersonal transformation at street level (Harris et al., 2014). Harris concludes that by strengthening street-level accountability and engendering respectful, empathetic provider practices - a restorative shift from older authoritarian modes - is vital to improving access to services and contributing more generally to the restoration of justice and health in society (Harris, 2016).

In 2018, in the aftermath of police shootings of black men in the local community, the UC Davis health system hosted a series of racial healing circles. Key to the success of this intervention was involving HCPs, faculty, students and members of the community in circles that “break down power hierarchies and create an environment where everyone was equal” (Behel & Lawson, 2018, p.3). This egalitarian approach is a prerequisite to creating an environment where participants feel comfortable sharing experiences related to discrimination and race-related harm or trauma. The intervention consisted of four three-hour restorative circle sessions, hosted at academic medical centers, which proved to be quite profound to those who joined. Among the benefits cited were an improvement in the ability to see other people’s struggles and increased in comfort at work due to improved sense of personal agency, the ability to speak up for themselves. (Behel & Lawson, 2018).

However, the long-term benefits of the racial healing circles may be harder to extrapolate. The circle practices themselves did not lead to institutional-level solutions, such as new policies or structural changes aimed at protecting black, indigenous, and people of color (BIPOC). However, according to Davis (2019), “healing interpersonal harm requires a commitment to transforming the context in which the injury occurs: the socio-historical conditions and institutions that are structured precisely to perpetuate harm” (p. 35). In the context of a healthcare organization, racial healing circles may be used to acknowledge the harm/trauma related to racism that can occur both in the community at large and within the healthcare organization. Furthermore, this case study opens the door to the possibility of using circle practices in healthcare to address unjust health equity harm (at the community level) as well as institutional-level racial bias incidents that may occur between HCPs.

An emerging field of study within K-12 education is evaluating the role RJ plays in social determinants of health. While it has been well established punitive, exclusionary and zero-tolerance approaches in K-12 education perpetuate the school-to-prison pipeline (Birmingham Ed Foundation, 2019). Gonzalez et al., (2019) reveal exclusionary school discipline (ESD) also compounds existing social, economic and health disparities. In fact, the authors radically shift the narrative regarding the impact ESD has on health status—reframing ESD as a public health crisis. For example, Gonzalez et al. (2019) discuss the high correlation between suspensions and academic disengagement and dropout. As a social determinant of health, the lack of education impacts emotional wellbeing and places students at increased risk for social and economic instability, chronic disease, and low life expectancy (Virginia Commonwealth University, 2014).

Furthermore, ESD promotes school disconnectedness, the feeling of being “unvalued and unwelcome,” which according to the CDC (2020), puts students at a higher risk for adverse

health and educational outcomes. For students of color, LGBTQ+ youth, and/or students with disabilities, who are already marginalized by higher rates of adverse childhood experiences (ACEs) scores and other traumas, ESD has a compounding effect on stress, feelings of fear and isolation, and mistrust of adults (De La Vega & Etow, 2019). Gonzalez et al. (2019) advocate for the broad implementation of RJ as both an education and public health strategy to improve school climate, relational capacity, school connectedness, promote self-regulation and conflict resolution skills, and increase social capital (Morgan et al., 2014; Knight & Wadhwa, 2014; Gonzalez et al., 2018; Macready, 2009; Schumacher, 2014). While these outcomes have short-term benefits, namely creating productive learning environments, the long-term benefits may play a critical role in the health outcomes of children and adolescents.

Todic et al. (2020) performed a quantitative analysis of the impact a whole school approach to RJ had on physical and mental health outcomes and academic achievement. They conducted a cross-sectional analysis of 6,992 middle school and high school students nested in 32 schools in California, which has a district-wide RJ policy. Using data from the 2013/2014 California Healthy Kids Survey (CHKS), the authors hypothesized the following:

1. Students attending schools which implement RJ will have better health and academic outcomes compared to students who do not, and
2. RJ moderates the relationship between individual level predictors (self-reported ethnicity and gender) among African American, American Indian, and Latino boys because they bear the disproportionate impact of ESD (Todic et al., 2020).

Using a two-level hierarchical linear model, the researchers determined the following positive outcomes: (1) the whole school approach to RJ had a protective effect, reducing the odds of physical health-related absences by 16%, (2) the use of peer-led RJ in a school predicted a

0.52-point increase in average grade, compared to schools not using RJ. However, the results concluded RJ did not reduce the odds of missing school due to mental health reasons or moderate the relationship between individual predictors (sex and ethnicity) and, therefore, did not benefit African American, American Indian, and Latino boys more than other students as predicted (Todic et al., 2020).

The authors argue that a whole school RJ approach is a structural intervention, which promotes health by altering structural context within which health is produced and reproduced (Blankenship et al., 2006; Brown et al., 2019; Shackleton et al., 2016). Harsh discipline in a school environment, they argue, contributes to the cumulative effect of social inequity and stressful environments, which leads to increasing allostatic load. Allostasis and allostatic load focuses on how individuals perceive and have or do not have confidence in their ability to cope with the burdens of life experiences (i.e., a sense of control as reflected in perceived stress) and contributes to health decline (Forde et al., 2019; Geronimus, 1992; McEwin, 2012). However, social integration and social support, which are tenets of RJ, have been demonstrated to reduce the impact of allostatic load (McEwin, 2012), which is not just beneficial for health but also in congruence with Henderson & Jackson's (2014) definition of restorative health.

Finally, Lokugamage and Pathberiya (2017) look to RJ as a means of addressing conflict in the context of human rights in childbirth. Published in the aftermath of a legal ruling, *Montgomery v. Lanarkshire* (2015), and through an "inflamed feminist" perspective, the article is nested in an ongoing global debate on the role of human rights in maternity care. Specifically, the authors address some of the limitations of evidence-based medicine, citing its technocratic, paternalistic, and low-compassion faults, and the effect this has on women's autonomy to make healthcare decisions (Lokugamage & Pathberiya, 2017).

The article also exposes some of the systemic issues that healthcare professionals experience as a result of working in the current technocratic NHS model “where complex health, social, political and economic elements are protocolized, guided by risk, cost and fear, at the expense of personalized care” (Lokugamage & Pathberiya, 2017, p.?). In fact, in light of several healthcare crises within the NHS, the authors argue the importance of seeing the delivery of care through the eyes of the patient (Lokugamage & Pathberiya, 2017). According to the authors, some of the etiologic factors responsible for negative health outcomes included stress, lack of resources (time, training) as well as the inability to engage with patients and community in humanistic ways (Lokugamage & Pathberiya, 2017).

Citing some of the outcomes of compassion-based healthcare (Youngson, 2012), the authors posit that storytelling (for both the patient and the healthcare professional) can serve to connect disparate parties to their common humanity (Lokugamage & Pathberiya, 2017). Interestingly, they reveal the transformational effect a narrative-based approach has on the healthcare professional. Based on two confidential forums called compassion rounds, the Schwartz Center and Balint groups, where healthcare professionals can reflect on the emotional and social challenges of work (Lokugamage & Pathberiya, 2017; Reed et al., 2014; Van et al., 2015), they state, “through staff stories regarding clinical care surrounding demanding situations, the narratives create an empathic understanding about themselves and their own colleagues which can spill over to generate compassion for their patients” (Lokugamage & Pathberiya, 2017).

Conclusions/Opportunities for Future Research

Harris et al. (2014) revealed the role healthcare professionals play in helping a country transition from a repressive state to a justice state. They unveiled the concept of restorative

health, which is the right of restoration to healthy functioning. Behel and Lawson (2018) demonstrated the power using racial healing circles in response to police shootings of black men, namely the interpersonal, organizational, and extra-organizational capacities healthcare facilities may hold—and their ability to heal communities differently.

Gonzalez et al. (2019) and Todic et al. (2020) reframe the impact exclusionary school discipline (ESD) has on children and adolescents, highlighting its deleterious effects on health outcomes and life expectancy. When juxtaposed with Harris et al.'s work (2014), RJ can be viewed as preventative medicine among children and adolescents experiencing ESD and therapeutic (restorative medicine) among those who have been denied access to the social determinants of health. Lokugamage and Pathberiya (2017) reveal the inequities women experience in accessing healthcare and having autonomy to make informed decisions about childbirth.

Opportunities for future research include the addition of longitudinal, quantitative studies of healthcare outcomes among students exposed to RJ. In addition, capturing students' voices, through thematic analyses might reveal additional health benefits to participating in whole school and peer-led approaches to RJ. In regard to racial healing circles, a more robust, bioecological analysis of where healthcare organizations are nested in relation to larger social contexts, needs to be examined. However, the use of qualitative research methods can certainly begin to explore the work that is already being done in that space.

RJ and Malpractice Harm

In the medical malpractice space, Carroll and Reisel (2018) advocate for the introduction of restorative practices in healthcare by sharing their experiences using RJ in maternity care ward at an NHS hospital in England. According to Carroll and Reisel (2018, p. 224), “in the vast majority of cases, harm is caused by systemic errors and minor oversights that are not intentional.” To be clear, the authors are referring to medical malpractice harms that can occur from a healthcare provider to a patient due to negligence. According to the National Patient Safety Agency (2011), *patient safety incidents* are defined as “any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS care.”

Since Carroll and Reisel’s (2018) chapter in the *Routledge International Handbook of RJ* is considered a seminal piece, a considerable amount of time will be devoted to interrogating their methodology and findings. Although not based on the results of randomized and controlled trial, Carroll and Reisel (2018) not only effectively introduce the concept of RJ, but they transfer its key components contextually into the issues that afflict the healthcare system and its stakeholders. For example, when evaluating the fallout of an individual incident of malpractice harm, the authors conclude that harm has occurred to three distinct groups: (1) the patient/family, (2) the healthcare staff, and (3) the healthcare system (Carroll & Reisel, 2018).

For the patient and their family, who typically feel disempowered when seeking redress from a healthcare provider/system that has let them down, being listened to in a timely manner can be invaluable. According to the authors, “numerous patients felt forced to seek monetary compensation through court proceedings when all they wanted was to be heard and for the healthcare system to ensure that the harm that befell them would not be repeated.” (Carroll & Reisel, 2018, p. 226). For the healthcare provider(s) who were involved in harming the patient,

dealing with distress and shame can be painful, but especially so when they are not given the opportunity to make contact with the harmed party. “Whether it is to seek clarification or to offer an apology, far too often staff are told that the matter will be dealt with by other professionals.” (Carroll & Reisel, 2018, p. 228). Finally, for healthcare organizations, “the strain of patient safety incidents and their management is a severe burden on an already struggling health service.” (Carroll & Reisel, 2018, p. 225).

The authors point out two additional variables that are barriers to redressing healthcare harms, “blame culture” and the challenges procedural solutions such as *Serious Incident Review* pose. When a healthcare provider is embedded in a blame culture, they rarely are willing or able to take responsibility for the harm they have caused. As a result, an opportunity for resolution and reintegration is lost, with the incident continuing to define them (Carroll & Reisel, 2018). Serious Incident Reviews, which typically employ root-cause analysis methodology, are cited as methods that exacerbate the miscommunication between healthcare provider and the harmed patient. When a serious medical error occurs, typically senior doctors and nurses are charged with the responsibility of conducting an investigation. However, both the healthcare provider(s) who caused the harm as well as the harmed party (the patient and their family) are typically excluded from this process. In fact, according to the National Health Service (2017), a report investigating the cause of cerebral palsy claims from 2010-2015 found that only 40% of the cases included the patient or their family in the review.

Excluding the patient and healthcare provider from the incident review and/or legal process can have deleterious effects for the entire system. For example, when a patient enters a legal dispute, the healthcare organization does not have the opportunity to learn from the incident and change its practices accordingly. Consequently, the patient/family don’t get their needs met,

HCPs don't get the opportunity to take responsibility for their actions, and the healthcare system doesn't learn from the experience so as to prevent the same type of harm from occurring in the future. "The learning from the event must be embedded in the process change, and this requires an open approach to exploring the event, with all parties involved in that task." (Carroll & Reisel, 2018).

As much as the authors advocate for the integration of RJ as a new methodology in healthcare, just as importantly, they advocate for a change in the culture of healthcare—the interpersonal dynamics that occur between HCPs. In fact, the quality of the relationship between the staff (HCPs), the service users (patients) and the organizational teams are cited as hallmarks of the RJ approach as well as safe, effective service. According to Carroll and Reisel (2018), creating a restorative culture means having a template in place that addresses issues of tension when they arise. This includes valuing open communication, learning from mistakes, and knowing how to engage and listen when it matters. Theoretically, then, the ability to engage a harmed patient at a personal level in the aftermath of an incident is dependent on the ability of the HCPs to engage each other and their organizational teams in the same way. Finally, citing a shift from medical paternalism toward patient autonomy, the authors conclude, "renewed emphasis is placed on patient-centered care, which attempts to include the patient and their family in the resolution of a conflict" (Carroll & Reisel, 2018, p. 227).

The authors extol five benefits of using a restorative approach in healthcare, framed as an opportunity for dialogue in addressing shared situations of concern. They are as follows:

1. Offers participants a chance to address and understand the event,
2. Gives the patient (and their family if relevant) a voice and the ability to participate in dialogue to address the scope for resolution,

3. Gives the staff member the ability to integrate the event into ongoing safe practice as a valued clinician,
4. Enhances life skills for conflict situations for both parties, and
5. Maximizes opportunity for organizational learning (Carroll & Reisel, 2018).

The authors conclude with descriptive data from an intervention, a RJ pilot in a maternity care setting. Their intervention began with an electronic survey of physicians and midwives working in a tertiary teaching hospital in London. The response rate was 40% (n=105) and demonstrated the following: (1) on average physicians and midwives had been involved in two serious safety incidents in the previous year, (2) only 30% of those surveyed had received individual feedback relating to the incident, and (3) almost all of the surveyed indicated they would like to have both individualized feedback and further training on how to conduct better conversations with affected patients (Carroll & Reisel, 2018).

Following the survey, teaching sessions on restorative practices were created for both physicians and midwives working in the labor and postnatal ward. Particular emphasis was placed on addressing the blame culture that occurs in healthcare, beginning with altering the language away from the binary limits of right versus wrong, to a concern with the impact of the event on all parties and their needs moving forward (Carroll & Reisel, 2018).

Earlier work by Holmes-Bonney (2010) explored the role RJ plays in managing patient complaints in health and social care in England. In response to new regulations issued by England's Department of Health (DH) in 2009, which aimed at resolving patient complaints locally and "built around the needs of individuals and not services providers," the government implemented a pilot program called Making Experiences Count (DH, 2007). The pilot consisted of 93 sites which tested the effectiveness of a new complaint management program, which was

meant to resolve the organizational challenges of the previous complaint process, which were: (1) too prescriptive and inflexible to meet the needs of complainants, (2) too fragmented, so that different complaints procedures had to be followed depending on the nature of complaint and identity of complainant, and (3) did not emphasize the local, quick and effective resolution of problems (DH, 2005).

The pilot program provided the health minister sufficient feedback to help restructure the program from one focused on process management to one focused on patient-centered outcomes. It also changed the relationship between complainants and the subjects of their complaints from an adversarial to a collaborative one in which both parties seek resolutions that can improve services (Holmes-Bonney, 2010). However, as was also noted by Carroll and Reisel (2018), the shift from medical paternalism to one that is patient-centered is not devoid of its organizational challenges. Holmes-Bonney identified two barriers to implementing the new legislation aimed at guiding the management of health and social care complaints: blame culture and poor listening on the part of HCPs.

According to Holmes-Bonney (2010), the strategic implementation of RJ as a solution to the above-mentioned challenges requires a leadership approach that shifts the focus from finding an individual to blame when an adverse event occurs to an analysis of the entire process. “By refraining from casting blame, managers can understand why these events occur, and prevent the events from occurring again” (Holmes-Bonney, 2010, p. 14). Additionally, she highlights the difficulties HCPs exhibit in listening deeply to patient complaints, especially when the issue cannot be solved through clinical interventions, but rather through understanding and empathy. Ultimately, she summarizes, “organizations need to develop this level of collective emotional

maturity if they are to create open and responsive cultures, and effective approaches to complaints management” (Holmes-Bonney, 2010, p. 15).

Citing the success of RJ in the criminal justice system, and noting the organizational barriers at play in the complaint management program, Holmes-Bonney recommends healthcare organizations create the conditions necessary for complaints to be resolved based on mutual trust, respect and emotional articulacy (Dignan, 1992). In the case of an adverse event, which ultimately led to harmed relationships and a patient complaint, Holmes-Bonney advises placing the need to repair the harm above the need to blame and punish. Through allowing the complainant and those they complained about to convene, understand what has happened to the other, and support and learn from each other, a resolution can be found (Holmes-Bonney, 2010).

Although Holmes-Bonney doesn’t go into the particulars of how RJ could be implemented procedurally, she identifies it as a useful tool that can be used by complaint managers to create an environment conducive of resolving conflict. However, her paper’s greatest contribution comes from elucidating how the Department of Health’s new regulation played a critical role in expanding the capacity to manage complaints at the local level, and thus, creating an opportunity for RJ to be used more broadly to redress complaints in healthcare. As healthcare systems and organizations look to RJ as a way of addressing medical errors, resolving disputes and redressing harm, leadership support from the top down will be essential. Organizational dynamics that lend to smooth collaboration between departments and other agencies were also cited as necessary components of this process change.

Farrell et al. (2020) raise the stakes further by examining the merits of using a restorative approach for redressing gross negligence manslaughter cases by HCPs within the NHS in England. The article thoroughly interrogates the General Medical Council’s (GMC) increasingly

punitive approach in handling cases of fatal medical errors over the past 10 years, which although rare, have led to prison sentences and medical practice suspensions (Farrell, 2020). However, unlike Holmes-Bonney (2010) and Carroll and Reisel (2018) who advocated for a “no-blame culture,” Farrell et al. (2020) cite a shift by the GMC towards a “just culture”, which involves the following components:

1. Systems, procedures and processes surrounding the criminal law and medical regulations being applied,
2. Healthcare professionals would be able to learn without fear of retribution,
3. Healthcare professionals would also be encouraged to admit to errors in such cases, and
4. Necessary steps would be taken to ensure they, patients and their families were dealt with in a fair and compassionate manner. (GMC, 2019).

The new guidance would use RJ to shift away from the criminalization of HCPs towards rehabilitation as well as create opportunities for victims to find healing and redress. The values of *redress* and *rehabilitation* would underpin the new approach, with redress encompassing payment of financial compensation, explanations, apologies, professional accountability, and systems learning to prevent the harm from occurring again (Vincent et al., 2012). This shift toward rehabilitation is substantiated by an examination of the current retributive model, which emphasizes deterrence and plays both symbolic and expressive functions (Farrell et al., 2020). However, given the lack of evidence that criminal prosecution leads to deterrence coupled with the fact that “fatal error cases arise which involve no deliberate wrongdoing and are interwoven with systemic failures in healthcare environments,” the authors propose establishing a RJ pilot in cases of GNM against healthcare professionals (Farrell et al., 2020, p. 15).

The authors clarify the role RJ could play in cases of GNM as *complementary* to the current retributive model (Farrell et al., 2020) rather than being an explicit alternative. They note preference findings from Daly (2002), that “combinations of retributive, restorative, and rehabilitative elements may be influenced by participants’ differing understandings of punishment, retribution, and punitiveness.” In using restorative conferences to convene the offender and victim in dialogue, the authors heed a warning about the process being less formal than the retributive model, and they note the importance of ensuring the rights of all the parties were protected, and that appropriate procedural safeguards are in place for the conduct of the process (Farrell et al., 2020). Procedurally, Farrell et al. borrow from the United Nations’ guidance on the basic principles of RJ in criminal matters framework, which includes:

1. Establishing the conditions and criteria for referral and review of cases,
2. Ensuring that informed consent had been obtained from victims regarding their participation,
3. Developing protocols to manage power asymmetries between parties,
4. Facilitating consultation with legal representatives both before and after legal proceedings,
5. Requiring facilitators involved in RJ meetings be appropriately qualified, and
6. Providing ongoing financial support to facilitate the participation of parties in such programs (United Nations, 2002).

With regard to oversight of the pilot specifically, Farrell et al. (2020), recommend a multidisciplinary panel made up of professional regulators, prosecutorial authorities, the criminal justice system, NHS, and peer and lay members who would oversee policy development, assessment, referral, and evaluation of the pilot. Although the authors don’t explicitly describe

the strategy that should be employed to evaluate the pilot's success, they state it should be "in the interests of transparency, accountability, and policy learning" (Farrell et al., 2020). Farrell et al. (2020) conclude by suggesting RJ could potentially be employed to address a broader range of harms suffered by patients and their families as a result of healthcare malpractice, findings which were also substantiated by Carroll and Reisel (2018) and Holmes-Bonney (2010).

As may be evident by now, limited research has been published on the actual use of RJ in healthcare. However, Braithwaite et al. (2005), observed restorative exit-conferences in nursing homes in the United States and Australia where stakeholders (inspectors, managers, proprietors, staff representatives, representatives of the residents) convene to discuss the health and safety risks that exist in the facility. Then, any trust that has been breached and relationships damaged by allowing these risks to exist is explored. This is typically followed by a plan of action which includes symbolic reparation (an apology) and material reparation (compensation) to the resident or staff who have been affected (Braithwaite et al., 2005). However, they caution, "some health services already operate in a restorative way, but this happens unsystematically rather than programmatically" (Braithwaite, 2005, p. 29).

Open disclosure is described by Wellington (2004) as a process of discussing incidents that resulted in harm to a patient as a result of the care they received, which is consistent with tenets of just culture, which was also supported by Farrell et al. (2020) and Kauer et al. (2019). Two hallmarks of open disclosure are an apology and systems learning that ensures an event is less likely to take place in the future (Braithwaite, 2005). Furthermore, an open approach to medical mishaps is ethically, morally, and professionally expected of clinicians (Oakley & Cocking 2001; Lamb 2004; Irvine 2004). Additional benefits of open disclosure include (1) doctors are less likely to be sued (Gallagher et al., 2003), and (2) in the Veterans Affairs (VA)

health system, notifying patients who have been adversely affected has had the unanticipated financial benefit of reducing its malpractice burden (Kraman & Hamm 1999).

One prospective study, which was conducted by Kaur et al. (2019), evaluated the practical and economic effects of implementing RJ in a medium sized community and mental health trust in England. An NHS Trust is a legal entity, set up by order of the Secretary of State, to provide goods and services for the purposes of the health service (NHS, 2020). In the case of Mersey Care, which services more than 11 million patients across 85 acute and outpatient sites in Northwest England, the intervention fundamentally changed its responses to incidents, patient harms, violence, and complaints against staff (Mersey Care, 2020). This mixed-methods study, which was conducted over an 18-month period, evaluated the shift from a retributive just culture to a RJ culture they termed “just and learning culture” (Kaur et al., 2019). Pre and post intervention qualitative interviews were conducted as well as quantitative analyses of costs, suspensions, and absenteeism (Kaur et al., 2019).

Prior to the implementation of RJ in 2015, the researchers conducted qualitative interviews of frontline staff in order to create a thematic analysis of the climate at Mersey Care. Their findings indicated the following: (1) staff reported a major fear of being blamed for adverse events, (2) staff were not always telling the truth, (3) half the clinical staff acknowledged they felt inhibited to speak out about adverse events, and (4) there was a sense among staff the organization was solely target-oriented and lacked openness and compassion (Kaur et al., 2019). From an economic standpoint, incidents led to suspensions, dismissals or sanctions, which had a cumulative effect on rising legal and staffing agency costs (Kaur et al., 2019).

The intervention was a comprehensive shift in the way adverse events were dealt with, which included proactive and reactive components. In regard to managing incidents, Mersey

Care held “restorative conversations” between all stakeholders in the incident rather than investigations of supposed offenders. Additionally, they implemented a freeze on staff suspensions (unless contraindicated by evidence of threat), several HR policies were edited to remove judgmental language (which previously held staff accountable by procedure and compliance standards), improved the promotion and quality of staff support, and shared best practices and successes through an internal microsite (Kauer et al., 2019).

In order to determine outcomes of the 18-month RJ intervention, the researchers conducted qualitative interviews of several executive level personnel, including Mersey Care’s CEO. Methodologically, this was a deviation from the original strategy used to determine the baseline (retributive) climate. By not conducting post-intervention interviews of front-line staff on their perceptions of the cultural change, the researchers introduced bias into their qualitative analysis. Therefore, the staff experience benefits, which were attributed to the introduction of RJ, were determined solely on the perceptions of people in upper-level management who presumably exerted positional power over the front-line staff. It’s also important to note the initial (retributive culture) findings included 4 discreet themes, whereas the post-intervention (RJ) findings included 22 discreet benefits. Again, methodologically, the outcome data could have been coded into categories and themes.

The tangible, non-economic effects of RJ were determined by an analysis of suspensions, absenteeism, etc. (Kauer et al., 2019). According to the authors, these benefits were as follows: (1) 44% decrease in the number of disciplinary and suspensions cases, (2) an increase in reporting adverse events (7%-18% per year from baseline), (3) 25% increase in requests for counseling/support, and (4) a non-quantified reduction of issues presented regarding bullying, career, formal procedures, health, job situation, employment, trauma and violence/assaults

(Kauer et al., 2019). The economic effect, which is this study's most statistically robust assertion, was a cost-savings of approximately 2.5 million euros due to a reduction of absenteeism, which accounts for 1% of the company's operating costs and 2% of the labor costs (Kauer et al., 2019).

Finally, Wailling et al. (2019) discuss the New Zealand Ministry of Health's national RJ intervention addressing the harms related to the use of surgical mesh. Surgical mesh is a medical device that is used to provide additional support when repairing weakened or damaged tissue (FDA, 2020). The study is a thematic analysis of over 600 consumers, family members, Whānau (extended family), healthcare professionals, and healthcare stakeholders who participated in various RJ discussions, which occurred between July and October 2019. This included in-person listening circles and conferences and an online database that allowed the researchers to capture the stories in written, audio and video form. The result was a co-designed process focused on the harms, needs and reparative actions identified in all of the sessions (Wailing et al., 2019).

The most impressive part of this feat was the government's commitment to provide an opportunity for those adversely affected by mesh to share their experiences of living with surgical mesh (Wailing et al., 2019). The leadership and organizational aspects of this undertaking need to be highlighted and contextualized because they expose the role government support—from the top down—plays in redressing harm in cases involving large populations. With so many stakeholders affected by surgical mesh harm, the government's decision to use RJ to rebuild trust in healthcare professionals, healthcare organizations, medical manufacturers, and the Ministry of Health is commendable. Furthermore, empowering the office of the chief medical officer resulted in building the capacity to redress harm by using a RJ, and, in doing so, those who were adversely affected by mesh were able to collaborate and be a part of the solution.

The planning phase included the use of circle practices with members of the ministry of health, the RJ team at Victoria University, and a surgical mesh advocacy group (Wailling et al., 2019). The framework used to guide the RJ intervention was the restorative inquiry framework (see Table 1), is focused on identifying harms and needs of those directly affected by mesh and to clarify accountabilities for repair (Wailling et al., 2019).

Table 1

The Restorative Inquiry Framework

Questions of Inquiry
1. Who has been hurt and what are their needs?
2. Who is responsible for the harm and what are their obligations?
3. How can things be put right again?
4. How can we prevent it from happening again?

The planning team decided on a three-phase approach, which included: (1) listening and understanding, (2) planning and acting, and (3) reporting and evaluating (Wailling et al., 2019). Ultimately, the researchers used the initial data from the listening circles to convene the “responsible parties” at an impact and action planning workshop which was held in November 2019. The full thematic analysis of the intervention has not been completed, however, the initial findings among persons affected by mesh revealed several categories of mesh-related harms, a loss of dignity and trust, distrust of HCPs’ technical expertise and integrity, distrust of health system and medical manufacturers, issues with informed consent, and gender inequality (Wailling et al., 2019).

Using the restorative inquiry framework, the needs identified were (1) credentialed surgeons, advocacy/support, psychosocial support, a mesh register, regulations on mesh use, and the right to complain and make informed choices (Wailling et al., 2019). The meetings with HCPs yielded insight into their need for credentialing, training on informed consent, creating a safety culture, and granting patients access to more services (Wailling et al., 2019). A plan of action was developed and agreed upon by stakeholders representing all parties affected by mesh, however, the 19-point plan focuses on rebuilding trust and preventing harm from befalling others (Wailling et al., 2019).

Conclusions/Opportunities for Future Research

Carroll and Reisel (2018) discussed some of the hierarchical, organizational and cultural issues that have limited HCPs' ability to engage a harmed patient/family in a restorative way. They reveal an incident of malpractice harms several stakeholders: the patient and their family, healthcare professionals, and the health system. In managing patient complaints, Holmes-Bonney (2010) identifies systems learning and no-blame culture as a key benefit of a restorative approach. In addition, she showcased the role policy regulations, specifically the empowerment of complaint managers at the local level, facilitated the integration of RJ in the complaint management process. Farrell et al. (2020) advocated for an RJ pilot as a way of creating a "just culture" in cases of gross negligence manslaughter. They viewed RJ as complimentary to the current retributive model by focusing on redress (for patients/families) and rehabilitation (for HCPs).

Brathwaite et al. (2005) presented findings from exit conferences in nursing homes and revealed some of the benefits of issuing an apology and creating an open disclosure culture. Kauer et al. (2019) showcase the only prospective study done using RJ in a healthcare setting.

Interestingly, their shift to a “just and learning culture” revealed less about its impact on healthcare workers specifically, and more about the organizational-level metrics (suspensions, absenteeism, disciplinary cases). Furthermore, the authors created an economic model, attributing RJ as a cost-savings strategy in a medium sized, multifacility healthcare trust. Finally, Wailling et al. (2019) demonstrate what a comprehensive, multitier response to patient harm looks like at the national level, which when one considers the lack of literature available to guide their efforts, it was certainly a good place to start.

Opportunities for future research include qualitative research focusing on patient and front-line staff experiences with the RJ, especially in response to a process change. Since Carroll & Riesel (2018), Holmes-Bonney (2010), and Farrell (2020) recommended piloting RJ in the malpractice space, robust pilots should include both quantitative and qualitative components, especially cost-savings data in cases involving litigation. Kaur et al.’s (2019) study can be used to model best practices for creating a top-down cultural shift and reducing spending due to absenteeism.

RJ and Mistreatment Harm

In the academic medicine sector, Behel and Lawson (2018) reveal a disturbing trend occurring among medical students nationally, a significant rise in incidences of learner mistreatment. According to the Association of American Medical Colleges' graduation questionnaire, 42% of medical students reported being mistreated at some point during medical school (AAMC, 2019). This data correlates with findings from the UK's General Medical Council's National Training Survey on bullying, which revealed junior doctors were described as receiving belittling or humiliation and threatening or insulting behavior. Behel and Lawson (2018) reveal, "academic medicine is not immune from disturbing reports of mistreatment and inequality, which includes unconscious biases, sexist language in lectures, and tongue lashings in the presence of patients" (p. 1).

Indeed, academic medicine offers unique challenges to restorative practitioners—the intersection of academia and medicine—each with its own set of hierarchies, power imbalances, structural demands, and stressors. The result: a "perfect storm" of sorts, a setting rife with amplified potential for harm to befall medical students, faculty, HCPs, patients, and staff. Demonstrating the far-reaching benefits RJ can offer academic medicine, Behel and Lawson showcase the use of RJ to two very different—and very timely—real-world scenarios. Presented as case studies methodologically, the first case employs the use of peer-led circle practices addressing student misconduct at Rush Medical College and the second case involves the use of racial healing circles led by the University of California Davis health system, which has been discussed in greater detail already.

In response to structural changes made to the curriculum at Rush in 2018, a group first- and -second year medical students began acting out—speaking harshly with students and

professors— and attempting to silence other students. The stress of the new curricular approach coupled with being separated with the larger cohort resulted in increased pressures as well as disconnection, which ultimately led to student-to-student misconduct. After receiving training in RJ, student leaders hosted voluntary RJ circles which provided both cohorts the opportunity to voice their hurt and concerns and to rebuild the sense of community that had been lost. During the circle practices students also reaffirmed their commitment to respect and care for one another. In response, the university created more opportunities for connection by hosting regular, low-cost social hours for the students. As a result, reports of student misconduct diminished significantly.

Through these brief case studies, Behel and Lawson (2018) highlighted some of the benefits of using Tier I community building circles in academic medicine and healthcare settings. At the Rush Medical College, specifically, the circles were used to ameliorate the harm and community fallout that resulted from student misconduct. However, the most powerful element that emerged from the RJ circles was the students' newfound ability to lead themselves through the identification of institutional issues that were creating stress and frustration among medical students. Furthermore, they used a collaborative approach to finding redress from incidents that caused harm/concern while simultaneously finding community-building solutions at the institution. Although this particular case addresses acts of verbal aggression and intimidation, in academic medicine community building circles can be used to address hostile climates, racial bias, and sexual harassment (Acosta & Karp, 2018).

Methodologically, Behel and Lawson (2018) provide two excellent case studies that demonstrate potential benefits of using RJ in healthcare/academic medicine. However, given the lack of empirical evidence supporting the application of RJ in these settings, an opportunity to

measure discreet outcomes was missed. For example, survey methodology could have been used to measure participant satisfaction, teamwork, leader-member exchange, etc. Similarly, qualitative interviews could have been conducted to create thematic analyses and more robust assertions about the benefits/challenges of using RJ to address student mistreatment and racial injustice. However, it's important to note that case studies, like the one's reviewed, not only inform a researcher's a priori knowledge about a topic, but they forecast the structural and methodologic challenges that may emerge once a more rigorous study is undertaken.

Acosta and Karp (2018) also address the issue of learner mistreatment in academic medicine, however, they shift the focus from the identification of mistreatment harm and quantifying its impact on learners to suggesting a comprehensive three tier process for redressing it. Additionally, they advocate for the application of RJ in the healthcare workplace specifically since the clinical setting has been identified by medical students as the location where mistreatment has been experienced from clerkship faculty, residents, nurses, and other HCPs (AAMC, 2019). Unlike Behel and Lawson (2018), who focused on the use of Tier I circle practices in academic medicine, Acosta and Karp (2018) extol the benefits of using the entire menu of the RJ continuum (see Figure 1), which can be used by higher education institutions and healthcare facilities to build and strengthen community relationships (Tier I), respond to individual incidents of harm or misconduct (Tier II), and facilitate the difficult processes of reintegrating an individual who is returning to the academic or workplace setting after a suspension or loss of specific privileges (Tier III) (Acosta & Karp, 2018).

The comprehensive model (RJ continuum; see Figure 1), which is intended to help “groups identify and gain mutual understanding of the personal and collective harm that has occurred,” (Acosta & Karp, 2018, p. 354) correlates with Carroll and Reisel's (2018) findings

that an individual incident of harm has affected multiple parties as well as the community, or system, as a whole. By utilizing a framework that addresses harm at various levels of analysis, Karp and Acosta conclude that “these conditions incentivize offenders to admit responsibility rather than deny or minimize the harm, and explore and define a set of problem-solving steps to address the harm and rebuild community trust” (Acosta & Karp, 2018, p. 354).

The authors also promote the use of reentry circles in order to strategically welcome back HCPs, faculty, students and staff into the community after a suspension or administrative leave. Borrowing from the criminal justice system, which uses circles of support and accountability to help formerly incarcerated offenders develop a life-management plans after their release from prison, Acosta and Karp (2018) suggest establishing a support system aimed helping medical students and HCPs reintegrate to their respective communities. According to the authors, the benefits are twofold: (1) for the offender, providing intentional and coordinated support and a road map for to follow could be instrumental to their future success, and (2) for the community, impacted members can express their true feelings to the returning offender regarding the impact he or she had on the staff, how best to repair the harm that occurred, and what conditional support will be provided with the hopes of rebuilding community trust (Acosta & Karp, 2018).

Citing positive outcomes of RJ in higher education, the authors advocate for the transferability of restorative practices into the academic medicine sector and health professions settings—the clinical facilities where medical students practice. These benefits include addressing broader campus-level issues such as a hostile climate, racial bias, and sexual harassment as well as mitigating individual incidents of harm such as learner mistreatment, healthcare provider mistreatment, and individual cases of sexual harassment and assault (Acosta & Karp, 2018). Finally, given RJs segue into healthcare and academic medicine is in the infancy

stages, Acosta and Karp (2018) recommend RJ facilitator certification, which is skills-based training aimed at helping future facilitators develop the skills, experience and leadership needed to implement comprehensive RJ processes at healthcare facilities and academic medicine institutions. This coupled with a comprehensive procedural framework, the RJ continuum, is argued as a process to help facilitators guide RJs implementation in academic medicine and healthcare settings.

In the same way Behel and Lawson (2018) and Acosta and Karp (2018) advocate for the application of RJ in academic medicine, nine years prior, Hutchinson (2009) identified RJ as a way of addressing workplace bullying between nurses. An important finding across all three articles was that exposure to mistreatment occurs during clinical placements, with students socialized into norms and practices in the workplace which are tolerant to bullying (Randle, 2003). According to Hutchinson (2009), in nursing, the exposure to aggression through bullying is so pervasive, it's comparable to high-risk occupations such as police and prison officers. She notes the impact of bullying spans across several stakeholders (individuals targeted, offenders, and witnesses), and can lead to avoidance strategies, withdrawal of commitment at work, patient medication errors, and staff resignation (Duffield, 2007; Hutchinson, 2009).

Hutchinson begins with an overview of the literature on nurse bullying, highlighting the lack of progress made in more than two decades of advocacy against it (Duffy, 1995; Dunn, 2003; Roberts, 2000). Before presenting a typology of individual vs organizational approaches to workforce bullying (see Figure 3), she describes the three main types of bullying that occur in nursing: (1) erosion of professional competence and reputation, (2) personal attack, and (3) attack through work roles and tasks (Dilek & Yildirim, 2008; Hutchinson et al., 2008). In addition, she describes the complex interaction of workgroup and organizational characteristics

that result in nurses being acculturated into tolerant work groups that normalize bullying to the extent it is considered “part of the job” (Green, 2004; Jackson et al., 2002). This leads to passively tolerating or ignoring witnessed bullying, fostering a culture of silence, which ultimately increases the likelihood of repetition and reduces available social support between group members (Hutchinson, 2009).

Since social and work group strategies have been largely excluded from the solution to nurse bullying, Hutchinson (2009) proposes a typology (see Figure 3), which includes organizational-focused strategies.

Figure 3

Typology of Approaches to Workplace Bullying

Type of Approach		
	Remedial	Corrective
Individual Focus	<i>Counselling & mediation</i> <ul style="list-style-type: none"> ♦ Emotional support and counselling for targets ♦ Mediation between perpetrator and target 	<i>Education and behaviour modification</i> <ul style="list-style-type: none"> ♦ Education on behaviour codes ♦ Disciplining the bully ♦ Individual behaviour modification ♦ Aggression de-escalation training
	Regulatory	Restorative
Organisational Focus	<i>Policy and legislation</i> <ul style="list-style-type: none"> ♦ Harassment and discrimination legislation ♦ Occupational health and safety policies and legislation ♦ Zero tolerance and reporting policies 	<i>Shared responsibility & shared concern</i> <ul style="list-style-type: none"> ♦ Non punitive responses based upon shared concern ♦ Restorative circles and conferencing ♦ Fostering pro-social work group behaviour

Herein she proposes the use of organizational restorative strategies which shift the focus from a breach of organizational policy (regulatory approach) to attention on bullying as a human violation which requires the perpetrator to make amends within the context of a supportive group

that assists in restoration and re-integration (restorative approach) (Morrison, 2002). Through the use of restorative circles and conferences, Hutchinson argues that a shared responsibility/pro-social model would involve those who have a stake in a wrongdoing collectively identifying and addressing the harm caused through engendering active responsibility to put things right (Brathwaite, 2002).

Although Hutchinson (2009) goes into great detail outlining the restorative circle process, which is adapted from Pikas (2002) and Braithwaite (2006), and tailored to nurse bullying cases, she devotes less attention to convening restorative conferences and re-entry circles—combining both processes into one single meeting—this being in disagreement with the three-tiered continuum described by Acosta and Karp (2018). However, in concert with Acosta and Karp (2018) and Behel and Lawson's (2018) recommendations, Hutchinson (2009) advocates for the adoption of RJ in nursing education first, followed by the clinical setting. She identifies multiple ways in which RJ can be used in nursing education programs, which include: (1) shifting from a retributive approach to bullying toward a process for establishing justice and shared responsibility, (2) using integrity boards to convene conferences to address student misbehavior, (3) using conferencing to address individual incidents of bullying (student-to-student, faculty-to-student or vice versa, and faculty-to-faculty), and (4) employing a restorative pedagogy to help model the values and skills of shared responsibility and create transformational learning opportunities (Hutchinson, 2009).

Hutchinson also recommends using RJ circles in clinical nursing units as a strategy to interrupt the cycle of bullying to which students are exposed. In addressing patient medication errors, she recommends RJ as a non-punitive approach to foster democratic and healthier workplace relationships (Hutchinson, 2009). However, she cautions against implementing a

restorative approach to bullying without addressing two institutional variables: organizational culture and bureaucracy (hierarchical accountability and control), noting, “broader effects can be achieved when restorative philosophies, practices and principles are embedded within an organization’s culture” (Hutchinson, 2009). Finally, given RJ’s potential to disrupt or challenge institutional power dynamics, she proposes adequate training and support by facilitators trained in RJ (Hutchinson, 2009).

According to Lokugamage and Pathberiya (2017), the high rate of bullying experienced by healthcare professionals in the NHS, which is not limited to trainee doctors, is attributed to endemic issues afflicting the entire healthcare system. Lokugamage and Pathberiya (2017) make clear that several staff members (junior and senior) as well as consultants in obstetrics and gynecology experience bullying at the hands of lead clinicians, clinical directors, clinical secretaries, career grade doctors, patients, administration managers, general practitioners, and board-level executives (Lokugamage & Pathberiya, 2017; Shabazz et al., 2016). Unlike Hutchinson (2009) who categorizes nurse bullying as; (1) erosion of professional competence and reputation, (2) personal attack, and (3) attack through work roles and tasks, Lokugamage & Pathberiya (2017) expand on the definition of bullying by adding: freezing out, ignoring or excluding and continual undervaluing of an individual’s effort.

Finally, the most notable example of using RJ in the academic medicine setting is the Dalhousie University Dental School case described by Llewellyn et al. (2015). The highly public and controversial sexual harassment case involved 13 male dental students who made offensive comments about 5 female dental students in a private Facebook group they maintained, which reflected misogynistic, sexist and homophobic attitudes (Llewellyn et al., 2015). When the female students became aware of the posts, they filed a sexual harassment complaint, at which

point the university gave them the option to pursue a formal versus informal process. RJ was categorized under the informal category, a policy which had been in place at the university since 2010. The comprehensive RJ approach, which spanned over a 5-month period, not only addressed the individual incident but also the institutional-level culture and climate (Llewellyn et al., 2015).

During the investigation period, the male students were suspended from clinical practice in order to ensure no safety risks to patients and in consultation with the Faculty of Dentistry's Academic Standards Class Committee (ASCC; Llewellyn et al., 2015). The university's RJ approach was modeled after a familiar healthcare processes: investigate, diagnose, consult with patient and others, and remedy (Llewellyn et al., 2015). Paramount to the success of the RJ intervention was taking a holistic approach, which included multiple discussions, meetings, education sessions, restorative circles and conferences. There were instances where only the victims and offenders were convened in circle practices and other sessions were held where other stakeholders, including faculty, administrative and community members, were present.

Of particular importance was the training that facilitators provided the male dental students, which totaled 150 hours (Llewellyn et al., 2015). This included education on sexual harassment; rape culture; the intersectionality of gender, sexuality, race, and culture; power and privilege; human rights; and bystander intervention (Acosta & Karp, 2018; Llewellyn et al., 2015). In addition, the facilitators investigated the climate and culture within the faculty that may have influenced the offensive nature of the Facebook group's content (Llewellyn et al., 2015). The investment, though controversial, ensured men met the professional standards set by the ASCC in order to fully reintegrate in the didactic and clinical settings by fully understand the harm they caused.

In order to support a more inclusive and respectful culture and climate in the Faculty of Dentistry, the University, and the profession, the student participants in RJ hosted a *Day of Learning* toward the end of the process in order to share their experiences and learning in connection with these five themes: (1) Community Building, (2) Inclusion & Equality, (3) Professionalism & Ethics, (4) Curriculum & Program Structure, and (5) Reporting Process & Conflict Resolution (Llewellyn et al., 2015).

Conclusions/Opportunities for Future Research

Behel and Lawson (2018) revealed disturbing statistics about learner mistreatment in academic medicine and advocated for the use of RJ by presenting two cases studies, one on student misconduct in the academic medicine setting and the other on racial injustice in the clinical setting. Acosta and Karp (2018) offered a comprehensive solution to learner mistreatment by citing RJ outcomes in higher education, and through presenting the RJ procedural continuum, which integrates restorative conferencing and circles of support and accountability (re-entry circles). They also advocated for skills-based training in RJ leading to certification.

Hutchinson (2009) created a typology of individual and organizational responses to nurse bullying, citing RJ as a way to address shared responsibility and shared concern. She also revealed nurse bullying begins in the clinical setting and recommended an RJ pilot in nurse education first, then in the clinical setting, which is congruent with Acosta and Karp's (2018) recommendations. In the hospital setting, Lokugamage and Pathberiya (2017) exposed some of the systemic and cultural factors that contribute to the pervasive issue of bullying of healthcare professionals in the UK. Finally, Llewellyn et al. (2015) responded to an incident of sexual harassment, which was nested in a larger climate issue at the Dalhousie University Dental

School. Their comprehensive, multidisciplinary approach included every aspect of the RJ continuum, and the experience was used to educate the offenders and the community at large.

Opportunities for future research in this space include a systematic evaluation of the harms experienced by medical students, faculty, HCPs, and staff at both academic medicine institutions and clinical settings. This process can begin with qualitative interviews to help determine themes, which could be used to inform theory and create an RJ intervention aimed at redressing the harms identified therein. There is a gap in the literature on the role climate circles, conferencing and reintegration play in redressing harm in healthcare and academic medicine. Ideally, a multistage study of this type would cumulatively evaluate the application of the entire RJ continuum in a stepwise fashion. Lastly, quantitative methods could be used to determine the magnitude and frequency of mistreatment in academic medicine and healthcare as well as other outcomes (e.g., employee retention, patient safety incidents, absenteeism, and satisfaction with the process), just to name a few.

CHAPTER THREE

METHODOLOGY

Research Design and Staging

For this research study, I employed a 3-stage exploratory sequential mixed methods design. This methodology was suitable for bridging the health and social sciences because it employed qualitative inquiry first, which helped inform the secondary (RJ intervention) and tertiary (quantitative) stages of the study. According to Merriam and Tisdell (2016), when little is known about a particular population or subject, the qualitative data are used to *explore* and define the topic in order to create a survey instrument to gather data from a larger sample. I used the restorative inquiry framework (see Table 1) to explore the type of workgroup related harms HCPs, medical students, and nursing students experienced, identify what needs emerged, and determine how health systems responded to those harms. However, the data also revealed additional themes which had not previously been discussed in the literature. Thus, the study augmented existing theory and created new knowledge.

Table 1

The Restorative Inquiry Framework

Questions of Inquiry
1. Who has been hurt and what are their needs?
2. Who is responsible for the harm and what are their obligations?
3. How can things be put right again?
4. How can we prevent it from happening again?

Furthermore, because the study included several RJ interventions, the Tier I and Tier II restorative circles, qualitative data were used to inform the development of the RJ interventions in a similar way that qualitative research might precede quantitative data collection in experimental designs. According to Creswell and Clark (2011), “qualitative data collection may precede an experimental trial to inform development of procedures or follow an experimental trial to help explain the results of the trial” (p. 8). Finally, both qualitative interviews and data obtained from the RJ interventions, both inductive processes, were used to create a quantitative survey, a deductive process, which was used to evaluate the outcomes of the circles. According to Creswell and Clark (2011), mixed methods research employs rigorous *qualitative* research exploring the meaning and understanding of constructs and rigorous *quantitative* research assessing magnitude and frequency of constructs.

The merger of these two data sets, embedding the quantitative survey within a larger qualitative design, maximizes the strengths and minimizes the weaknesses of each type of data (Creswell & Clark, 2011). Therefore, conceptually, and chronologically, the staging of this research study was as follows:

1. Qualitative Stage (explored the problem)
2. Intervention Stage (implemented a new solution to the problem: RJ), and
3. Quantitative Stage (evaluated the effectiveness of the RJ intervention)

Qualitative Research (Stage 1)

To understand the impact workgroup mistreatment had on healthcare professionals, medical students and nursing students, I relied on purposeful sampling techniques. According to Merriam and Tisdell (2016), purposeful sampling is based on the assumption the investigator

wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned.

Participant Selection and Research Sites

A healthcare provider or learner who has experienced workgroup-related harms can provide more *information-rich* insights of central importance to the purpose of the inquiry than an average healthcare provider. Therefore, the following inclusion criteria was established to guide in the identification of information-rich cases:

1. HCPs, healthcare administrators, human resources professionals, or faculty members in academic medicine ages 18 and over who have:
 - a. At least 6 months experience working in the hospital setting, or
 - b. Medical students and nursing students who have begun clinical practicums or residencies in hospitals, and
2. Meet at least one of the two characteristics listed below:
 - a. Have experienced workgroup-related harms due to someone else's misconduct/harassment/intimidation/bullying, or
 - b. Have supervised, managed or advised another healthcare provider, medical student, or nursing student who has experienced workgroup-related harms or caused workgroup-related misconduct/harassment/intimidation/bullying.

For the qualitative stage, a sample of 12 healthcare professional, at all levels of the clinical hierarchy, which included medical students and nursing students, were recruited throughout the United States. In addition to relying on the inclusion criteria listed above, this study employed maximum variation sampling (MVS), which aided in exploring widely varying instances of the phenomenon (Glaser & Strauss, 1967). The rationale for using MVS is based on

two premises: (1) a review of the literature has revealed healthcare misconduct occurs throughout all the disciplines in the healthcare delivery chain; not just among physicians and nurses (Vukmir, 2016), and (2) common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central shared dimensions of a setting or phenomenon (Patton, 2015).

Ultimately, sampling continued until a point of data saturation and redundancy was reached given the purpose of the study (Patton, 2015). This was achieved with a total of 12 interviews. I recruited participants directly through their medical school, nursing school, or healthcare facility by using a research flyer (see Appendix A), which was distributed in person and/or via e-mail to prospective participants throughout the United States. In total, 7 out of 12 participants interviewed identified as female and 5 out of 12 identified as male. Most participants were registered nurses ($n = 5$), followed by physicians ($n = 2$), human resources managers ($n = 2$), and nursing students ($n = 2$). Most participants were recruited from California ($n = 6$), followed by Massachusetts ($n = 4$). Most of the participants interviewed (6 out of 12) were between 25 and 34 years of age. To better understand the variation among the study's participants, refer to the demographic data provided in Table 2.

Table 2

Demographic Characteristics of Research Participants

Pseudonym	Gender	Race	Age	Position	Region
Tracy	F	White	35–44	Registered nurse	California
Sally	F	White	25–34	Respiratory therapist	California
Michelle	F	White	45–54	Human resources manager	UK
Quentin	M	AAPI	25–34	Resident physician	Massachusetts
Roger	M	Black	25–34	Registered nurse	Alabama
Michael	M	Latinx	25–34	Registered nurse	California
Roselyn	F	White	45–54	Physician	Massachusetts
Kevin	M	AAPI	25–34	Nursing student	California
Norma	F	White	25–34	Nursing student	California

Sharon	F	White	45–54	Human resources manager	Massachusetts
Carol	F	White	45–54	Nursing manager	Massachusetts
Benjamin	M	Latinx	35–44	Registered nurse	California

Qualitative Data Collection Procedures

Once the study’s participants had been recruited, I obtained informed consent verbally, electronically (via Qualtrics), or in writing by using a consent form (see Appendix B). The primary data collection method was semi-structured interviews. An interview guide (see Appendix C), which lists the questions and topics that are to be explored during the interview, ensures the same basic lines of inquiry are pursued with each person interviewed (Patton, 2015). The interview guide was reviewed in advance by my dissertation committee. Additionally, the guide was pilot tested with at least two social science researchers to ensure it effectively captured the constructs required to answer the study’s first three research questions:

RQ1: What types of workgroup-related harms do HCPs, student learners, and healthcare teams experience in the acute-care setting?

RQ2: What impact does workgroup mistreatment have on HCPs, student learners, and healthcare teams?

RQ3: In what ways, if any, are healthcare organizations and/or academic institutions responding to workgroup-related harms?

I then conducted the semi-structured interviews in person, over the telephone, or via the Zoom video conferencing platform. The interviews provided a checklist of topics to be explored while allowing for a natural, open-ended conversational flow to emerge. According to Patton (2015), “the interviewer remains free to build a conversation within a particular subject area, to word questions spontaneously, and to establish a conversational style but with the focus on a particular subject that has been predetermined” (p. 343). Although participants were advised

they may be contacted for a second interview, this proved to be unnecessary. The average length of the interviews was 60 minutes.

During the interviews, I took handwritten notes using standard journaling techniques, which helped inform further inquiry, reflection, and analysis. Additionally, most interviews were audio/video recorded using the Zoom video conferencing platform; however, two interviews were recorded using a cellular phone. I then had the interviews transcribed using an online transcription service (Scribie.com) which password protect the files. The research journal, interview transcripts, and audio recorders were kept in a locked cabinet to ensure participant privacy. The files were also protected by using password protected computer and cellular phone.

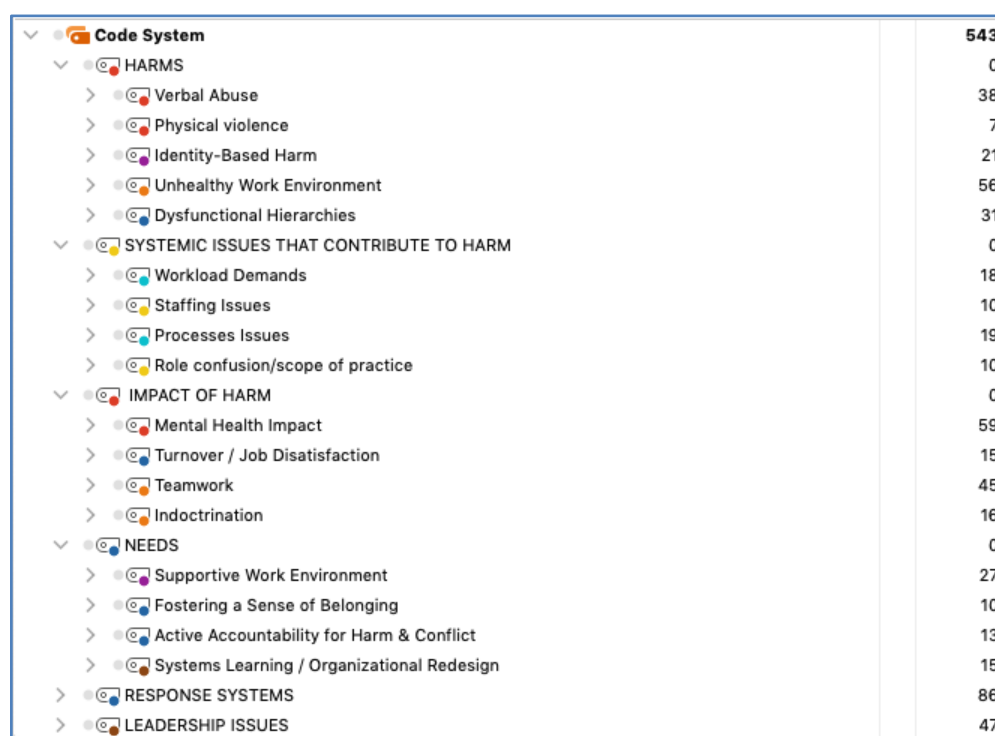
Qualitative Data Analysis

The qualitative stage employed a within-case/cross-case thematic analysis design using the restorative inquiry framework. After all the interviews had been conducted and transcribed, each participant's interview was treated as a case. As the researcher and the primary data collection instrument, I looked for themes and/or patterns that emerged in the data of the transcriptions, which were read line-by-line, categorized or coded, and then tabulated case-by-case using MAXQDA coding software. Initially, I prioritized the following themes: harms, needs, response systems, which correlate with the questions from the restorative inquiry framework. Each case was then thoroughly interrogated, analyzed and interpreted in narrative form. Afterwards, some participants were contacted and asked if the interpretation of their interviews matched the meaning of what they had said. This process, known as *member checks* or respondent validation, increased the credibility of the study by helping determine if the interpretation of the emergent findings "rang true" or required fine-tuning or modification (Merriam & Tisdell, 2016).

After all the cases were analyzed, coded and tabulated, it was clear several additional themes had emerged, including but not limited to the impact of harm, systemic issues that contribute to harm, and leadership issues. I then reduced the data set into a manageable number of codes that were truly reflective of the study's overall purpose, which was achieved by combining codes and sub-codes. I created a spreadsheet (thematic matrix; see Figure 4), where the themes were arranged categorically across all cases, which allowed me to get a bird's-eye view of the entire data set. In total, I recorded 543 codes across all 12 interviews. Finally, I systematically interpreted the data in narrative form, one theme at a time, for the purpose of analysis, theorization, and discussion.

Figure 4

MAXQDA Thematic Matrix



Code System	Count
Code System	543
HARMS	0
Verbal Abuse	38
Physical violence	7
Identity-Based Harm	21
Unhealthy Work Environment	56
Dysfunctional Hierarchies	31
SYSTEMIC ISSUES THAT CONTRIBUTE TO HARM	0
Workload Demands	18
Staffing Issues	10
Processes Issues	19
Role confusion/scope of practice	10
IMPACT OF HARM	0
Mental Health Impact	59
Turnover / Job Disatisfaction	15
Teamwork	45
Indoctrination	16
NEEDS	0
Supportive Work Environment	27
Fostering a Sense of Belonging	10
Active Accountability for Harm & Conflict	13
Systems Learning / Organizational Redesign	15
RESPONSE SYSTEMS	86
LEADERSHIP ISSUES	47

RJ Intervention (Stage 2)

Participant Selection and Research Sites

The goal of the RJ intervention was to recruit several healthcare workgroups with a shared interest in redressing climate concerns at their institutions, and to expose them to community building circles. Therefore, leaders from healthcare, academic medicine, and academic nursing settings were invited to volunteer a workgroup, cohort, or clinical team that was experiencing unhealthy relational dynamics (climate concerns), specifically related to mistreatment (intimidating and disruptive behaviors), teamwork, or burnout. Another research flyer (see Appendix D), with specifics about the intervention phase, was distributed in person and/or via e-mail to prospective participants throughout the United States.

Ultimately, the intervention stage of the study recruited two distinct workgroups (which were treated as separate cases) and were selected based on convenience and safety factors. Given the dynamic nature of the COVID-19 pandemic, and the need to protect research participants' health, the research sites were given the option to participate in-person (while masked) or convene via videoconferencing platform (e.g., Zoom, Microsoft Teams, Skype). Thus, RJ interventions (community building circles) were successfully piloted with the following workgroups in the following settings:

1. ***Student Nurses:*** A sample of 53 student nurses from a master's degree level nursing program in Southern California (in-person circles),
2. ***Medical Students:*** A sample of 280 (first year, second year) medical students from a medical school in Washington state (in-person circles).

More detailed case studies of the two RJ interventions, and their respective quantitative outcomes, will be discussed in the quantitative findings section of Chapter 4.

Designing the RJ Intervention

The RJ interventions were designed to answer the study's fourth research question: *In what ways, if any, do HCPs and medical students benefit from the use of Tier I-II restorative circles to deal with workgroup-related harms?* Answering this question was particularly important since many scholars have advocated for the transferability of RJ into healthcare/academic medicine without much empirical evidence of its effectiveness in those settings. Unfortunately, since using RJ to ameliorate harms in healthcare is still in its infancy stages in the United States, case studies and quantitative data are not yet readily available. According to Merriam and Tisdell (2016), a case study is a single unit, a bounded system from which a sample is typically selected. Therefore, this study was uniquely positioned to create two case studies through exposing medical students and student nurses to two separate RJ interventions. In doing so, the study exercised a certain amount of control over the intervention and, thus, it ensured evidence-based RJ approaches (fidelity to the circle process) were used to conduct the circles.

I helped design and co-facilitate one of study's RJ interventions, the student nursing circles which were held at the University of San Diego (USD) on November 17, 2021. Through collaborating with Justine Andreu-Darling, PhD, an experienced RJ practitioner and professor, Dr. Bridget Frese, PhD, PHN, CNL, CNM, clinical associate professor at the Hahn School of Nursing, and 5 RJ facilitators from USD's Center for RJ, a collaborative approach was taken in planning, designing, and facilitating the RJ intervention. Additional details on the restorative justice in academic nursing (RJAN) case study are available on page 121. The medical student RJ intervention was co-designed by Toni McMurphy, an independent RJ practitioner who specializes in academic medicine, and Dr. Mirna Ramos-Diaz, MD, MA, FAAP, the chief diversity and inclusion officer and associate professor of pediatrics at Pacific Northwest

University (PNWU). Through training additional students, faculty and staff at PNWU, the RJ team built the capacity to deliver a total of 10 community building circles between August 11, 2021 and December 8, 2021. Additional details on the restorative justice in academic medicine (RJAM) case study are available on page 127.

Through sharing information about the themes identified during the qualitative stage of the study, the circles were designed to address the needs of a healthcare audience. For example, since the qualitative analysis revealed breakdowns in psychological safety, teamwork, and diversity issues were linked to workgroup mistreatment, the circles were designed to address those issues specifically. Thus, in keeping with both clinical research and RJ traditions, the intervention component had the capacity to directly respond to the harms and needs of some of the study's participants. The community-building circle protocols used in this study can be found in the following appendices: student nursing circles (see Appendix E), academic medicine circles (see Appendix F).

Conceptually, then, as the primary researcher, I maintained a certain level of objectivity by evaluating the effectiveness of the intervention as a *participant observer* in one case (the student nursing circles), and strictly as a quantitative researcher in the other cases (academic medicine and healthcare). According to Merriam and Tisdell (2016), "the participant observer sees things firsthand and uses his or her knowledge and expertise in interpreting what is observed rather than relying on once-removed accounts from interviews" (p. 139). Another benefit of observational research is the researcher can clarify what was observed in the circles through "anchored interviewing," (p.139) which is asking the participants what they were thinking with regards to specific behaviors witnessed on site. Ultimately, anchored interviews were conducted

with a total of two individuals (student nurses) who participated in the community building circles.

Analyzing the RJ Intervention

The intervention stage was evaluated in two ways, through the primary researcher being a participant observer (in the student nursing circles), which was explained in the previous paragraph, and via quantitative survey (Stage 3), which is explained in greater detail below. Since the climate circles also included discussions about workgroup mistreatment, the researcher integrated mental notes, reflective memos, and interleaved findings of the anchored interviews into the final analysis. Furthermore, the five co-facilitators of the student nursing circles were asked to document a post-circle summary, through reflective memos, which were shared in a collaborative document that was made available immediately after the circles were conducted. Thus, this study used a systematic process of integrating the data from the intervention stage with the data from the qualitative stage as a means of *triangulation*, which increases both the quality and validity of the research and confirms emerging findings (Merriam & Tisdell, 2016). This was achieved by rigorously interrogating the summary data of the circle experience for commonality in themes, parallels, and paradoxes with the findings of the qualitative analysis.

Quantitative Research (Stage 3)

Participant Selection, Data Collection and Survey Design

For the quantitative stage of the study, an online survey was designed and distributed electronically (via Qualtrics.com and SurveyMonkey.com) to the medical students and student nurses who participated in the RJ interventions (the community building circles from Stage 2). The purpose of the survey was to evaluate the effectiveness of the RJ intervention through measuring participants' perceptions of the circle experience. Thus, it was necessary to design an

instrument that could: (1) capture fidelity to the circle process, (2) measure the various dialogical and relational phenomena that emerge during circles, and (3) help establish salient connections between the concrete outcomes of the circles and the needs HCPs reported from the qualitative stages of the study. Therefore, the strategy for designing the multivariate instrument included:

1. Incorporating data obtained from the qualitative stages, which informed harms, needs, and barriers to communication HCPs, medical students, and student nurses were experiencing,
2. A review of the *Essential Elements of a Circle* (see Appendix G), as determined by Boyes-Watson and Pranis (2015), which is considered a seminal piece, and the model by which contemporary restorative circles are designed and facilitated, and
3. A content analysis of 12 RJ evaluation instruments, which helped determine the theoretical and operational constructs other RJ practitioners/evaluators have identified (to this point).

Unlike other experimental research methods, surveys can measure several variables and may test multiple hypotheses simultaneously (Neuman, 2011). In this instance, once the constructs had been explored, understood, and operationalized through fine-tuning the questionnaire, the benefits of RJ circles in healthcare could be determined. In addition to measuring certain demographic characteristics (e.g., age, gender, ethnicity, occupation), the questionnaire asked respondents to self-report their beliefs, opinions, expectations, and experiences with the circle process (Neuman, 2011). Therefore, the primary theoretical constructs (categories) the instrument sought to measure were:

1. Building and Strengthening Relationships (through storytelling and ceremony)
2. Creating an Inclusive and Equitable (non-hierarchical) Dialogue Space

3. Improving Group Relations/Teamwork (aimed at improving the climate)
4. Alignment of RJ Values and Healthcare Values
5. Work Intentions (after experiencing RJ)

The operational constructs (variables) the questionnaire sought to measure, at least initially, were:

1. Building and Strengthening Relationships (through storytelling and ceremony)
 - a. Seating, centerpiece and talking piece
 - b. Opening ceremony, mindfulness moment, and closing ceremony
 - c. Identifying community values
 - d. Restorative agreements (consensus on respectful, authentic, non-violent, and confidential dialogue)
 - e. Establishing emotional connections with peers and/or institution
 - f. Changing individual perspectives
2. Creating an Inclusive and Equitable (non-hierarchical) Dialogue Space
 - a. Equitable dialogue
 - b. Flattening the hierarchy
 - c. Elevating marginalized voices
3. Improving Group Relations (teamwork), which included:
 - a. Mutual understanding of complex phenomena
 - b. Increasing empathy
 - c. Reducing judgment
 - d. Reducing blame
 - e. Improving psychological safety
 - f. Addressing conflict

- g. Collaboration/Action Planning
- 4. Alignment of RJ Values and Healthcare Values
 - a. Alignment with the institutional values
 - b. Alignment with healthcare values
 - c. Alignment with goals of creating a just and learning culture
- 5. Work Intentions (after experiencing RJ)
 - a. Get to know colleagues better
 - b. Work toward more collegial environment
 - c. Work through difficult team issues using circles

The final questionnaire (see Appendix H) was developed to meet rigorous psychometric properties, which ensured validity and reliability of the desired constructs. However, prior to its broad distribution, the survey was further refined after conferring with two members of the researcher's dissertation committee, who helped edit some questions for style, grammar, and to ensure they were not measuring multiple variables (e.g., double, or triple-barreled questions). Pre-testing of the questionnaire was done with a total of eight participants, faculty members of a medical college, who had previously participated in community building circles.

For data analysis, the questionnaire included closed-ended questions using a 5-point Likert scale, which measures a wide range of opinions, perceptions and behaviors (Neuman, 2011). Additionally, some questions measured discrete frequencies, numerical ranges, and nominal values. Finally, some questions included a "free text" option where participants could manually enter a response denoted as "other." For example, if respondents were asked to identify their position or professional role, and if the options in the questionnaire did not include a matching option, the respondent was able to manually enter their response. To prevent

respondent fatigue, the questionnaire was limited to 32 questions, including demographic questions, and was administered online using USD's Qualtrics account to ensure data security.

Quantitative Data Analysis (Descriptive Statistics)

Although the questionnaire did not intend to yield causal relationships or determine statistically significant changes in any of the variables, it had the potential to elucidate the magnitude and frequency of RJ benefits in healthcare settings. Therefore, conceptually, what the qualitative inquiry lacked by focusing on depth, the quantitative inquiry intended to make up by focusing on breadth. Descriptive statistics were used to make associations, draw comparisons, and identify parallels between the qualitative data and the survey data.

I used the Statistical Package for the Social Sciences (SPSS) software program to analyze the data obtained from the questionnaire. Once the surveys had been completed, a worksheet of the raw data was uploaded to SPSS for statistical analysis. In addition to determining descriptive statistics (e.g., frequencies, percentages, central tendency), the data was organized in meaningful ways (e.g., graphs, tables, charts).

Data Integration

For this research study, the integration of qualitative and quantitative data sets followed systematic integrative procedures. According to Creswell and Clark (2011), there are three ways to integrate multiple forms of data: merging data, connecting data, and embedding data.

Although the quantitative component, the survey, was embedded in a primarily qualitative design, the data was analyzed separately then connected systematically. The qualitative and intervention stages were analyzed first, through narrative analysis, and that information was used to inform the subsequent data collection (quantitative survey), which yielded descriptive statistics on the benefits of RJ circles in healthcare settings. In this way, the integration occurred

by connecting the analysis of results from the initial phase with the data collection from the secondary and tertiary phases of research (Creswell & Clark, 2011).

Researcher Positionality

As a healthcare provider, RJ practitioner, and social scientist, I navigated multiple identities while conducting this research. My clinical background as a respiratory therapist has positioned me in the middle of the clinical hierarchy, thus, I have personally witnessed, experienced, and have likely been complicit in workgroup mistreatment. As a healthcare administrator, I have also resided at the pinnacle of the administrative hierarchy, which placed me in a position of power over several healthcare professionals. Furthermore, I have first-hand experience using RJ to redress harm and conflict in my own private practice, and as an RJ consultant. Though helpful in many ways, ultimately, those prior experiences play a role in my ability to conduct this research in an objective and non-biased manner. Through bracketing my own lived experiences, and approaching the research from a lens of curiosity, I was intentional in mitigating my biases. I also relied on reflective memos and respondent validation, which helped me identify instances when my personal biases were eliciting certain responses from my interviewees.

As an RJ practitioner, I also possess additional knowledge, training, and perspectives on restorative approaches to harm and conflict, which prioritize humane, collaborative, and dialogical approaches to redressing harm over punitive ones. These philosophical differences, and corresponding biases, may be perceived by my research participants, which could also influence their responses due to social desirability bias. According to Bergen and Labonte (2020), the social desirability bias denotes a mismatch between participants' genuine construction of reality and the presentation of that reality to researchers. Furthermore, my

enthusiasm for redressing harm in a restorative way could be perceived as a passive form of justice for individuals who expect accountability for harm to be punitive. Conversely, for individuals who have been socialized to tolerate mistreatment from certain HCPs, seeking active accountability for harm, through using an RJ approach, may make them feel uncomfortable or threatened.

As a social science researcher, I have accumulated additional knowledge and training on how to make meaning of social phenomena, namely social constructionism, a theory most HCPs are not familiar with. According to Thomas et al. (2014),

Social constructionism involves looking at the ways social phenomena are created, institutionalized and made into tradition by humans. Socially constructed reality is seen as an ongoing, dynamic process, and reality is reproduced by individuals acting on their interpretation and their knowledge. (p. 2)

Thus, when you consider my a priori knowledge on this subject matter, along with my ongoing interpretation and constructivism of the research findings, this places me at a knowledge advantage over the research participants.

Finally, my identity as a Latinx, cisgender male was also present and perceived in the research space. This privilege played a role in my research participants' willingness to answer questions truthfully, especially as it relates to discussing harm or mistreatment. However, given the identity-based harms that were revealed by Black, Latinx and AAPI respondents, being a researcher of color may have made them feel more comfortable discussing explicit racism and racial microaggressions.

CHAPTER FOUR

QUALITATIVE FINDINGS

To answer the study's first three research questions, I used the restorative inquiry framework (see Table 3) to help identify the *harms* HCPs experienced in the clinical setting, the *impact* these harms had on them individually and how that affected teamwork, and the resultant *needs* this created. Finally, from accountability and systems-learning standpoints, interrogating how organizations *responded* to these harms was crucial for several reasons. This determined if:

1. HCPs who have experienced workgroup mistreatment had their needs understood and met,
2. Those responsible for causing harm were clearly identified and held accountable for putting things right again, and
3. Future harm was prevented (both the institutional culture and structures responsible for causing harm were improved).

Table 3

Research Questions Matched to Restorative Inquiry Framework

Research Questions	Restorative Inquiry Framework
RQ 1: What types of workgroup-related harms do HCPs, student learners, and healthcare teams experience in the acute-care setting?	Who has been hurt and what are their needs?
RQ 2: What impact does workgroup mistreatment have on HCPs, student learners, and healthcare teams?	
RQ 3: In what ways, if any, are healthcare organizations and/or academic institutions responding to workgroup-related harms?	Who is responsible for the harm and what are their obligations?

Therefore, conceptually, any gap that exists between the needs HCPs reported and the

ways institutions responded to those needs creates a *restorative imperative*, which is a leadership precedent justifying the use of restorative practices in healthcare/medical learning environments.

Workgroup Harms in Healthcare

The term *workgroup mistreatment* was selected over the well-established concepts of lateral or horizontal violence, which have been described in the nursing field for decades. According to Alspach (2007), “lateral or horizontal hostility refers to a variety of unkind, discourteous, antagonistic interactions that occur between persons at the same organizational hierarchy level” (p. 10). Thus, the concept of workgroup mistreatment is intended to be inclusive of the hierarchical (vertical) and horizontal dimensions of mistreatment, in its various forms, and includes the dysfunctional workgroup dynamics that can lead to mistreatment, including but not limited to leadership, cultural, and structural issues that often precipitate healthcare provider harm.

The range of experiences with workgroup mistreatment, as reported by HCPs, medical students, and nursing students, varied significantly from everyday examples of incivility and disrespect (e.g., rudeness, degradation) to frank verbal abuse (e.g., beratement, harassment, public shaming), and a smaller proportion reported physical violence. Some providers reported identity-based harms such as gender and racial bias, which ranged from microaggressions to racist, sexist, or homophobic behavior. However, one finding that was salient across all participants interviewed was an unhealthy work environment (toxic organizational culture), whose harms were more insidious and ill-defined but significantly impacted their wellbeing and the quality of teamwork. Finally, of relevance to academic medicine/academic nursing populations were hierarchical harms, which resulted from abuses of power that were based on status ranking, affecting both clinicians and learners. An analysis of the themes that emerged are

described in greater detail as follows.

Verbal Abuse

HCPs, medical students and nursing students reported three main categories of verbal abuse: degradation, harassment, and public humiliation/shaming.

Incivility and Degradation

Acts of incivility and degradation included verbal and non-verbal forms of abuse by another healthcare provider, preceptor, or faculty member. In the most benign form, respondents reported non-verbal behaviors such as eye-rolling, being ignored (refusal to answer a question), and other passive-aggressive behaviors. However, more egregious forms included being yelled at or degraded, which included the use of curse words, personal insults and/or the use of demeaning language. For example, Quentin, a resident physician reported being berated by a surgeon in the operating room during a surgical procedure. He stated, “when something bad happens—a sudden bleed, for example, the surgeon starts yelling and cursing at the OR staff.” Tracy, a registered nurse who works in the intensive care unit (ICU), was insulted and blamed by a physician who was rounding on a patient he was hoping to extubate. According to her account, after the physician learned the patient’s gastric tube feeding had not been stopped, he stated, “you realize you caused a delay in this patient’s care—you’ll never be a good ICU nurse!”

However, some examples of degradation had nothing to do with a patient care scenario specifically. For example, Jesse, a first-year medical student, didn’t know he couldn’t take a patient’s medical record into an isolation room. As a result, he was yelled at by a charge nurse from the hallway. He stated, “I could see her yelling at me through the door, and she continued to yell at me as I exited the door, it went on for five to ten minutes.” Samantha, a student nurse, reported being degraded by a clinical instructor who disagreed with the way she handled a

medication question, stating, “She minimized me and made me feel really stupid. Instead of supporting me, or helping me understand, she asked me to look up the answer on the computer. Later in the shift, she joked about my incompetence with another provider.”

Harassment

Harassment was described as acts of bullying, intimidation, and territorialism. For example, Randy, a male float nurse whose work assignments vary depending on where he is needed, was harassed by a female physician during his entire shift. He stated, “she came back maybe like 10 minutes later and says, ‘so are you going to just sit there? Or are you here to help?’ And I’m like, just let me know what you need me to do, and I will help you.” Another nurse, Tracy, described working with a woman physician who is known for being difficult to work with. Tracy stated, “to the other nurses in the unit, she is known for being intimidating, and she just has that [no nonsense] personality.” These behaviors, Tracy believes, are a maladaptation to working in a male dominated field. “She’s modeling the behaviors of the other pulmonologists in the unit,” Tracy stated.

Several HCPs reported working with a charge nurse who was known for being particularly aggressive in their leadership style. For example, Carol, an RN, described one of her charge nurse’s supervision as follows, “they were very abrasive, very aggressive ... and this demeanor that was just very on guard and ready for battle.” In addition to aggressive communication in exercising leadership, some HCPs reported experiences with verbal and physical forms of territorialism, which means providers used certain tactics to protect their work environments as well as their patients. A respiratory therapist, Sally, who works in the neonatal intensive care unit (NICU), stated of the nurses there, “they hover over the residents...you can almost just feel that sense of they’re watching you, right...they’re very protective of their

babies.”

Benjamin, an experienced critical care nurse who was new to working in the cardiac care unit (CCU), described an experience with another nurse who interrogated him about his education, credentials, and clinical competence in the midst of providing patient care. He stated, “she wasn’t even in a supervisory role, but she was giving me a hard time because I had never worked in that unit before.” Another nurse, Tracy, said about a nurse who had been separated from the work environment, “we have a nurse on leave right now because she’s very difficult. It’s like whatever you do, it’s never enough, there’s always a fight against it, and the issue at hand.” Naturally, territorialism impacted medical students, nursing students and float staff more than other providers since their work environment is constantly changing. However, it is important to note these providers described a “vetting process,” by which house staff informally evaluated their clinical competence and established unwritten rules for working in that unit.

Public Humiliation and Shaming

In addition to individual accounts of harassment, blame and degradation, some of the most painful experiences reported by HCPs were accounts of public humiliation and shaming, which occurred in the presence of other HCPs, patients, or both. These instances typically occurred in the aftermath of a medical error, delays in patient care, or when the provider or medical student was perceived as being incompetent. For example, a medical assistant who mistakenly administered the wrong vaccine—and reported the incident immediately—was publicly reprimanded and insulted. According to Michael, who witnessed the exchange:

She was right next to the nurse’s station, and the doctor just started yelling, “How could you do that?” And I think she even she called her stupid. She’s like, “Did you not read the order?!”... She was very loud, and so everyone at the nurse’s station was listening and

could hear everything that was going on.

Public reprimands were also demonstrated by people in leadership positions, such as mid-level managers. Pam, a registered nurse working in the surgical intensive care unit (SICU) stated of her supervisor who responded to a medication error, “the supervisor, instead of being supportive or saying, ‘let’s take this to an office and talk about this in private,’ or ‘see what we can do,’ she started going in on the provider, like, ‘how could you make that mistake?’” Roger, a newly graduated registered nurse who was orienting in the operating room, was publicly ridiculed for not knowing surgical protocols. He stated of the charge nurse who was also gossiping about him to others:

He pretty much slandered my name, like if there were any issues that he saw with me in the room, he would have to go and report to the rest of the staff immediately. And so, the staff kind of had resentment towards me based upon what he was saying about me.”

Physical Violence

Although HCPs reported significantly fewer instances of physical assault or violence, a common sentiment shared among all respondents was working with a provider who was known for “throwing a tantrum” during a particularly stressful clinical situation. During these episodes, providers became verbally and physically abusive. For example, a pulmonologist who was frustrated because her resident was having difficulty intubating a patient, pushed the resident out of the way, lashed out at the respiratory therapist, and threw the endotracheal tube on the floor. The therapist stated, “the pulmonologist actually was very frustrated that we couldn’t [intubate the patient] and she expected me to grow multiple hands, right?”

In another instance involving a surgical procedure, a surgeon became frustrated with the way a surgical technician was positioning the instruments, so he grabbed her hand in an alarming

way. According to Sharon, a human resources practitioner who investigated the conduct violation, “he didn’t say, ‘I’m going to position your hand,’” he just grabbed it, and she said he grabbed it hard, and even said, ‘ouch.’” According to Roger, a traveling nurse, “a physician was so fearful of getting in trouble with the union, he became very apologetic after throwing an instrument which ended up hitting a nurse on the arm.”

Other forms of physical aggression were reported in response to workload assignments, delays in care, and negative patient care outcomes. For example, Tracy, a registered nurse stated, I’ve had nurses throw binders down or throw pens or throw the paper because they’re unhappy with their assignment, or a doctor, the doctor pounding his fist or... just knocking stuff off the desk, stupid stuff like that. Yeah, I have witnessed it multiple times.

Ali, a medical student who identifies as Asian American Pacific Islander (AAPI), reported being disappointed in her medical school’s response to a bystander intervention action plan she and other AAPI students developed to address anti-Asian violence. She stated, “AAPI physicians and medical students have been physically assaulted, and nobody seems to be taking this safety issue seriously.”

Identity-Based Harm

Interpersonal harms in the form of racial or gender bias, microaggressions, or insensitivity to social issues that afflict marginalized communities, were reported by both medical/nursing students and HCPs. Some of the accounts were shared by peers (bystanders who witnessed these harms) and others by human resources professionals (who responded to these harms).

Racial Bias

Experiences with racial bias varied from everyday reports of microaggressions to witnessing racist behavior from colleagues. According to Ehie et al. (2021)

Microaggressions are daily, subtle behaviors and attitudes toward others that arise from conscious or unconscious bias. Not only can they affect one's access to power, resources, and opportunity, but they could also contribute to the persistent disparities faced by marginalized groups among healthcare professionals as well as patients. (p. 132).

Michael, a Latinx registered nurse, recalled a negative experience with a White colleague who conflated his Latinx identity with stereotypes about Latinx occupations. He stated:

I had just finished cleaning a bed, I was setting everything up for a new admission when a Caucasian nurse came to me and was like, "Wow, you clean so good! Do you clean houses, too? Would you be interested in cleaning my house?" And I just remember not having the maturity or experience to be able to respond in that moment.

Michelle, a human resources manager of a multi-site health system noted, "systemic racism is imbedded into the organizational design...we need to redesign the system from the outside in." Working in a culture that feels unwelcoming to BIPOC HCPs, who are significantly underrepresented in the health professions (AAMC, 2019; Stanford, 2020), particularly affected a sense of belonging. Michael, a male registered nurse who identifies as Latinx stated, "I feel like as a man of color I'm used to being in environments that may not be welcoming at first, and I have to learn to cope, be resilient, and do what I need to succeed." Roger, a traveling nurse who identifies as Black, described how uncommon it is to see Black men, particularly nurses, in the medical field. As he recounted an exchange with a woman colleague at a hospital in Southern California, he stated, "When she first saw me, she was like, 'who is this guy walking around the OR like he owns the place?'" He elaborated, "I wouldn't have thought you were a nurse because

I've been working here for 10 to 20 years, and I've never seen a Black male nurse in our OR."

When fielding concerns about vicarious trauma afflicting Black HCPs, Michelle noted how insensitivity to social issues that afflict Black communities can compound harm and trauma. She stated, "what we've seen is that White colleagues don't understand the vicarious impacts of the trauma, of the George Floyd murder, the Black Lives Matter Movement, and what's happened with COVID-19." According to Edwards et al. (2019), Black men are about 2.5 times more likely to be killed by police over the life course than are White men. Additionally, Black communities in particular have been disproportionately affected by the effects of the COVID-19 pandemic. According to the CDC (2022), 34% of COVID-19 deaths were among non-Hispanic Black people, though this group accounts for only 12% of the total U.S. population. In a letter to the editor of the AAMC (2020), Kwaning, a Black medical student, wrote:

As a Black woman in medical school, I have had to cultivate ways to protect myself emotionally from the vicarious trauma triggered by witnessing the racially charged murders of Ahmaud Arbery, Breonna Taylor, and George Floyd on social media. I need to deploy coping mechanisms while learning the pathophysiology of diseases, medical management, and studying for the high-stakes United States Medical Licensing Exam. Sadly, balancing those responsibilities in effect precludes mourning. The disproportionate number of COVID-19-induced deaths among Black and indigenous patients has exacerbated this experience.

Vicarious trauma, also known as secondary traumatic stress, will be discussed in greater detail on page 103.

Gender Bias

Experiences with gender bias were rooted in healthcare's patriarchal foundation, and its

associated gender norms. Historically, men have occupied higher ranking clinical positions (e.g., physician status) with more power and privilege than women, who have traditionally occupied lower ranking clinical positions (e.g., nurse status). According to Hay et al. (2019), “women have less authority as health workers than men and are often devalued and abused” (p. 3). Although much progress has been made to close the gender parity gap in healthcare, including a significant increase in the number of women who are becoming physicians (AAMC, 2019), restrictive gender norms continue to reinforce gender inequality, which plays out in healthcare in several ways. Some nursing providers reported working in a culture where nurses (regardless of gender) are expected to be subservient to physicians (regardless of gender). Tracy, a registered nurse, stated, “nurses are viewed as being subservient people, especially to physicians. I know we’ve made big strides in healthcare against that ideal, and we’re supposed to work together, but it pervades to this day.”

Michael, a registered nurse who refused to wash a physician’s dirty dishes while working in a surgical setting, stated the following: “I was in a room getting ready for surgery, and a doctor comes in and puts her dirty dishes in the sink. I was like, ‘Oh, I’m sorry, I’m getting ready for surgery. Why are you putting your dishes there?’ And she said, ‘so you can wash them.’” The conflation of clinical roles with gender roles, as in the above example, was also found to be reinforced through reward systems. According to Michael, “I was not the favorite in the clinic because I wouldn’t pamper the physicians.” He noted the perception of clinical competency was conflated with non-clinical behaviors, like pampering:

Other nurses got positive feedback, like, “I can depend on you for the best wound care,” and “you’re my favorite nurse,” and things like that, and they were the ones who were definitely pampering those physicians.

Another form of gender bias afflicts the LGBTQIA healthcare workforce specifically. Fostering a sense of belonging for HCPs of all gender expressions, particularly members of the LGBTQIA community, is a challenge some respondents spoke about. For example, an anti-LGBTQ bias incident was reported by Tracy, a registered nurse, who witnessed one of her male nursing colleagues, who identifies as gay, being publicly harassed and shamed by another nurse. According to her testimony, her colleague was wearing an employer sponsored “Gay Pride” t-shirt, which made another female nurse extremely uncomfortable. She stated,

We have some Gay Pride shirts that we do sell with [the rainbow-colored company logo], and this particular nurse had a huge problem with it, and in the middle of doing rounds in the morning, she called him out in front of everyone.

Tracy reported being paralyzed by fear during the incident and stated, “I feel very guilty because I witnessed it, and I’m just one of those people that keeps my mouth shut and I’m so fearful for [losing] my job.”

Unhealthy Work Environments

The term “unhealthy work environment” was selected over *toxic organizational culture* based on restorative principles of non-violent labeling. In healthcare, as well as through restorative processes, healing can take on more than just a biological meaning. Therefore, the capacity to heal an unhealthy work environment, or climate, implies the potential for organizational transformation, for healing—for restoration. Labeling an organizational culture as toxic is not only derogatory but it may inadvertently designate HCPs or systems as poisonous, or malicious, which does not accurately capture the historical, structural, and cultural complexities that can lead to harm and dysfunction. Through analyzing some of the climate concerns HCPs and medical students reported, three salient themes emerged: (1) competitive organizational

culture, (2) blame culture, and (3) organizational silence.

Competitive Organizational Culture

HCPs reported working in a culture that is highly competitive and comparative, with exposure to rivalrous attitudes and behaviors at the interpersonal, departmental, and organizational levels. For example, through describing their colleagues as “prideful,” “egotistical,” and even “martyrs,” respondents shared the breadth of ways some individuals used their intelligence, educational level, licensure status, clinical ranking, and even burdensome (high acuity) workloads as symbols of superiority over others. Sharon, a human resource professional, described her experiences addressing conduct violations with physicians:

I think a healthy amount have very, very large egos. They like to be the smartest person in the room, and they get something from that. And they really do believe that we are mere mortals, and we should be privileged to be in their presence [because they save lives].

Enacting informal leadership was cited as another reason some providers use their personalities to assert dominance over others. Lynn, an HR manager stated, “they’ll assert certain things about their personality. Sometimes it’s with new folks, like, ‘just so you know, I’m top dog here, even though we’re peers.’”

Celebrating unrealistic workload, surprisingly, was another way HCPs asserted their superiority. Tracy, an ICU nurse, felt minimized by a colleague because she didn’t see the same volume of patients as nurses do at a neighboring hospital. She stated, “there’s a darker aspect to nursing, and that’s the [competitive nature] ...they don’t really view us as real ICU nurses because we don’t do as many procedures as someone at the bigger, outlying hospitals.” These sentiments were shared by another provider at a health system in Massachusetts, who stated, “In

healthcare, being a martyr is kind of sport, and there's competitions for who had the worst shift."

Sue, a nurse manager, quoted some of the comments made by nurses in her unit as a soliloquy.

She stated, "'Oh my gosh, that was the worst shift...I had so many patients...I was so busy...I didn't go to the bathroom...and 'I didn't eat.'—you know, this is all celebrated."

Some departments and teams were highlighted as being particularly prideful and difficult to work with. For example, Quentin, a resident physician, shared his perception of how some competitive behaviors are indoctrinated within teams. He stated, "it's funny because it's our surgeons, it's our surgical team and neurosurgery. It's just that mentality that they... really think they're better than everybody else, even the PAs that work for them." Roger, a traveling nurse who has worked in various hospitals throughout the United States, stated, "Honestly, I would say, ER and ICU are the most competitive without a doubt, because you tend to get the strongest personalities in these departments, very type A people." Sue, a nurse manager asserted, "Same for ER, right? A lot of ER nurses think they are better than other nurses."

Finally, competition was reported at the meso-level within health systems, too. For example, when describing the culture and competence at a multi-site health system in Massachusetts, Sue stated, "we have three community hospitals in our system, even within our system, we look down on the other community hospitals." Roselyn, a critical care physician described the health systems she works at as hyper-competitive, stating, "Within our own three hospitals, there is a ranking order, and it is clearly established. We're the best, and anybody that's not in this... in this box, you're lesser than us."

Blame Culture

HCPs, medical students, and administrators reported working in a culture where blame was used as a form of punishment, as well as a tactic to regulate behavior. For many of the

providers interviewed, this led to a paralyzing sense that any adverse event (even process issues beyond their control) would be used against them in a punitive way. For registered nurses, in particular, the burden of responsibility proved to be particularly distressing. Tracy, who described her job as a “wrangler in a circus,” expressed the phenomenon as follows:

We are responsible for everything. So, medications aren’t there on time, it’s still my fault, food’s not there on time, it’s still my fault, but the doctor didn’t come to the bedside when he had told the patient he would be there, it’s still my fault. It’s like we are constantly the source of everything that happens on the unit, and we get blamed for everything!

In many cases, providers used blame as a fear tactic to protect their patients from an adverse event or harm. This was characterized by hypercritical behaviors and verbal insults. Sharon described these tactics as a form of verbal abuse. Some examples she shared included, “What are you, stupid? You’re going to kill my patient! Get out of my OR!”

The impact of being blamed for a negative clinical outcome, medical error, or delay in care had far reaching consequences. For Tracy, the ICU RN who was blamed for delaying a patient’s discharge from the ICU, the experience resulted in feelings of guilt and shame mixed with feelings of resentment. Ultimately, she felt both she and the patient ended up being punished by the physician, by stating, “he basically just blamed me for the fact that the patient couldn’t be extubated and to prove a point he didn’t even extubate the patient that day.”

Another concern HCPs expressed was being blamed for something as a form of retaliation or sabotage. When workgroup dynamics are unhealthy, the fear of being reported by a colleague (for a systemic error), is particularly distressing. Tracy, and RN, stated:

In healthcare, there’s so many things that can go wrong, so if someone doesn’t like you,

they can really find a way to get you in trouble if they want... you can be reported and be fired, so in order to protect our livelihood, a lot of us stay quiet.

This sentiment extends to reputational damage, which may negatively impact career advancement, future job prospects, and the quality of relationships in future work environments, which was revealed by Tracy, who stated:

Healthcare in general is a small world, right? You run into people that you have worked with for 20 years when you go to another facility. I think the idea that the people that surround you are always kind of going to be in your orbit in healthcare, it's a matter of being buddy-buddy and safe in that environment.

Creating an environment where HCPs feel safe enough to discuss a patient safety incident is critical for continuous quality improvement (CQI) efforts. According to Cohen et al. (2003), “without changing the culture of blame, and thus releasing an avalanche of information, major improvement [in CQI] would not be possible” (p. 329). However, there are many reasons why HCPs use silence as a protective measure. Angela, a human resources manager, reported having difficulty getting HCPs to talk about a patient safety incident or near miss event. She stated, “we were amazed by what our staff told us by using our own data in terms of being scared, fearful, fearing of blame. In fact, it was a bit... Oh my God. It really was bad.”

Organizational Silence

When a healthcare provider is verbally abused or publicly shamed, they experience various impacts on their psychology, the quality of communication and teamwork, and their level of job satisfaction. However, many respondents expressed a compounding effect of harm when their colleagues witnessed their mistreatment but said or did nothing about it. According to Henriksen and Dayton (2006), organizational silence refers to a collective-level phenomenon of

saying or doing very little in response to significant problems that face an organization. Within the bounds of this research study, organizational silence was observed in three distinct ways: (1) when HCPs witnessed or conspired in mistreating another provider, (2) when a healthcare provider was in distress and needed social support, and (3) when healthcare leaders failed to address or minimized misconduct.

In the most benign form, being asked to adapt to a provider who is known for being rude, short-tempered, or disrespectful was described by Carol, an RN, as follows, “the staff was like, yeah, don’t worry about it. She’s like that with everybody. We just brush it off.” However, more severe examples reveal how organizational silence impacts self-esteem, trust, and compounds trauma. According to Michael, an RN who witnessed a medical assistant get publicly reprimanded for a medication error:

She just started crying, and then she would look at the nurses, like, ‘help me, or what do I do?’ And everyone just stayed quiet, and it was, even for me, very traumatic. That’s how you would treat an employee who made a mistake...because humans, we’re imperfect, and we’re bound to make mistakes.

Tracy, a nurse educator, described the isolating effect of having a colleague “turn away” as she was berated by a physician in the ICU: “when people turn away, it’s almost like they distance themselves from you...if you are at some level, possibly misconstrued as having done something wrong.”

When mistreatment does occur, minimal as it may be, respondents expressed concerns about reporting these offenses for fear their perspectives would not be believed by their managers, or that administration would not treat them fairly. Leadership favoring HCPs who are in a position of power (e.g., charge nurse or physician), and refusing to hold them accountable (if

they were responsible for harm or error), was cited as another reason some HCPs preferred to remain silent. When Sharon, a human resources manager was asked about how her organization holds providers accountable for mistreatment, she stated, “Usually we would [minimize the offense] and say, ‘okay, we’re good, let’s pretend nothing happened, and everybody play nice together.’”

From a workgroup relations (teamwork) standpoint, it is important to acknowledge the obvious disappointment HCPs shared in not being supported by their colleagues in situations where they were mistreated or experienced a distressing clinical event, medical error, or near-miss incident. The unfortunate “code of silence,” which in this study represented social discomfort with supporting a colleague or standing up for them publicly, represents a deep-seated cultural issue in healthcare. For witnesses of workgroup mistreatment, the retributive culture in healthcare is such a strong force, it inhibits their capacity to enact supportive behaviors (e.g., defend, speak up, allyship) and signals a severe lack of supportive dialogue and relational leadership.

Ultimately, the impact of working in a culture that is highly competitive, retributive, and blame-oriented results in some providers living in a constant state of fear and using organizational silence as a protective measure. These concerns are nested in a larger issue about the role hierarchy plays in credibility, favoritism, and accountability, which is discussed in greater detail in the next section.

How Dysfunctional Hierarchies Lead to Harm

To better understand how clinical hierarchies can result in HCP and student harm, it is important to understand the role clinical and academic hierarchies play in mentorship, supervision, autonomy, and abuses of power. To begin with, the term *hierarchy* refers to a group

of individuals ranked according to authority, capacity, or position (Walton, 2006). After the turn of the 20th century, healthcare systems, hospitals in particular, were organized into hierarchical structures that involved ever increasing power with each rank subject to the authority of the next level up (Walton, 2006). Historically, the physician has resided at the pinnacle of structure, occupying the highest rank, and thus having the most authority. In fact, modern-day physician training is still a derivative of the 19th century medical apprenticeship model (Starr, 1982). As healthcare has become more technologically complex and specialized, clinical hierarchies have expanded beyond academic medicine alone. Although physicians continue to occupy the highest clinical rank, and the power that accompanies it, hierarchies have expanded into nursing, pharmacology, rehabilitation, and health technology professions, just to name a few.

In the nursing professions, for example, there are at least five levels of nursing hierarchy (Jividen, 2021), which is illustrated in Figure 5. However, the table does not include registered nursing (RN) students, who are also stratified into three academic tiers: associate, bachelor, and master's levels, respectively. Post-professional nurses may obtain a master's or doctoral degree in nursing practice, too.

Figure 5

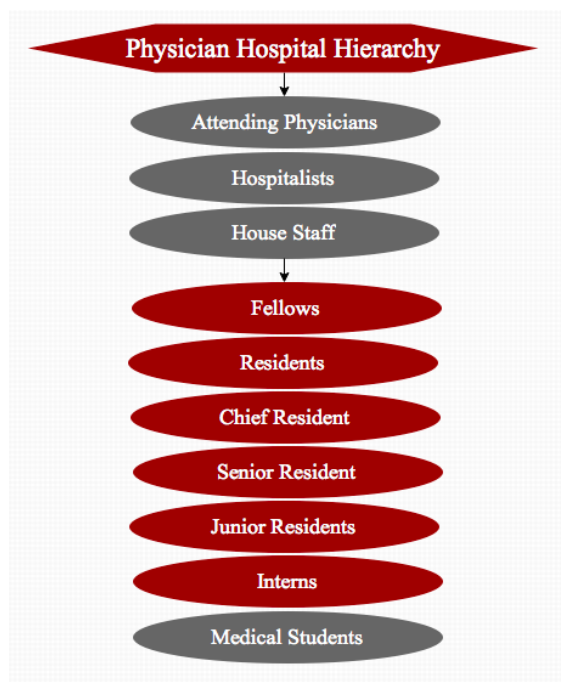
Nursing Hierarchy

	Education	Career & Salary Opportunities
CNA Certified Nursing Assistant	<ul style="list-style-type: none"> 4-12 week program CNA certification exam Earn a state license 	<ul style="list-style-type: none"> CNA Salary: <ul style="list-style-type: none"> \$30,830 per year \$14.82 per hour Job Outlook: <ul style="list-style-type: none"> 8% growth
LPN Licensed Practical Nurse	<ul style="list-style-type: none"> 1-year program NCLEX-PN licensing exam Earn a state license 	<ul style="list-style-type: none"> LPN Salary: <ul style="list-style-type: none"> \$48,820 per year \$23.47 per hour Job Outlook: <ul style="list-style-type: none"> 9% growth
RN Registered Nurse	Associate Degree in Nursing (ADN) <ul style="list-style-type: none"> 2-3 year program NCLEX-RN <hr/> Bachelor of Science in Nursing (BSN) <ul style="list-style-type: none"> 4-year program NCLEX-RN 	<ul style="list-style-type: none"> Registered Nurse Salary: <ul style="list-style-type: none"> \$75,330 per year \$36.22 per hour Job Outlook: <ul style="list-style-type: none"> 7% growth
APRN Advanced Practice Registered Nurse	Master of Science in Nursing (MSN) <ul style="list-style-type: none"> 2-3 year post-graduate program APRN roles must also complete in-person clinical hours and pass a certification exam in the area of specialization <hr/> Doctor of Nursing Practice (DNP) <ul style="list-style-type: none"> 3-4 year post-graduate program Requires capstone DNP project 	<ul style="list-style-type: none"> Nurse Practitioner (NP) <ul style="list-style-type: none"> \$111,680 Clinical Nurse Leader (CNL) <ul style="list-style-type: none"> \$104,107 Clinical Nurse Specialist (CNS) <ul style="list-style-type: none"> \$106,407 Certified Registered Nurse Anesthetist (CRNA) <ul style="list-style-type: none"> \$183,580 Certified Nurse Midwife (CNM) <ul style="list-style-type: none"> \$111,130
Non-Clinical Specialties	<ul style="list-style-type: none"> MSN DNP PhD 	<ul style="list-style-type: none"> Nurse Administrator <ul style="list-style-type: none"> \$89,015 Nursing Informaticist <ul style="list-style-type: none"> \$77,712 Nurse Educator <ul style="list-style-type: none"> \$77,451 Nurse Researcher <ul style="list-style-type: none"> \$72,019

In medicine, similarly, there are at least ten levels to the physician hierarchy, which is illustrated in Figure 6.

Figure 6

Physician Hierarchy



When you consider most HCPs interact with professionals of various specialties, and across several levels of the clinical hierarchy, the likelihood of being mistreated (due to hierarchical dynamics) grows exponentially. For example, it is quite possible that a medical student on their first clinical practicum may be degraded by a charge nurse for being unfamiliar with the unit and the unwritten rules of how the unit functions. However, that same nurse may be subject to verbal abuse by a resident physician because of a delay in patient care. Similarly, it is possible that the same resident physician may be publicly shamed in a clinical situation by an attending physician of the same or different specialty. It is important to note that the above examples are meant to illustrate how abuses of power are possible based on structural hierarchies that give some providers authority and influence over others. The variable that makes harm

possible in hierarchical dynamics is authority, which is defined by Merriam-Webster English dictionary (2022) as, “the power to give orders or make decisions: the power or right to direct or control someone or something.”

The following accounts of hierarchical harm span academic medicine, academic nursing, and acute care settings in healthcare. Before proceeding, however, it must be made clear that this paper does not advocate against the need for clinical hierarchies. The balance of safeguarding patients from harm or medical error (while a clinician or learner develops skills and clinical competency) is extremely important from a patient safety standpoint. However, understanding how hierarchical structures can increase the risk of interpersonal mistreatment, inhibit effective communication, and decrease the quality of teamwork, must be taken into consideration when exploring mistreatment in healthcare and learning environments. Finally, it is important to acknowledge that administrators/leaders (with or without a clinical background) are also part of the hierarchy in healthcare, typically occupying the highest ranks.

Generational Attitudes Toward Mistreatment

Given the historical underpinnings of medical apprenticeship model, and the need to use stratification as a clinical safeguard, it came of no surprise that some respondents attributed mistreatment to older HCPs who have largely gotten away with their offenses and are “set in their ways.” For example, Norah, a human resources manager, stated, “I find it's oddly a generational component, these are folks that perhaps in their training suffered far worse, and therefore they think they're angelic and supportive and view themselves as ‘very passionate, very direct,’ is what I've heard.” Another provider, Tracy, an RN, shared her frustration about communication barriers with physicians who have mistreated her, stating, “They get labeled as old, as a difficult physician. They just get a label, but no one does anything about it, and it all

goes back to hierarchy, so yeah, you just learn to be careful of those physicians.” This sentiment was echoed by Carol, an RN, who stated, “it's the older generation of physicians that are kind of stuck in this mindset of the nurse does what I say and doesn't question type of ideal.”

Liz, a human resource manager who testified against a physician at a conduct hearing, shared her concerns about his inability to accept responsibility for harm he caused. She stated, “We are going to counsel him out. He is not going to change, he's never going to admit he's wrong, he's never going to apologize, it's not in his DNA.” However, on a positive note, several practitioners expressed hope about the new generation of physicians emerging from medical school. For example, Sally, a respiratory therapist, stated, “our newer generation of physicians and providers, they're not afraid to speak up [against mistreatment]. We have residents who don't hesitate to complain about the behavior of faculty, and that didn't happen five years ago.”

Functional Hierarchies

In healthcare, functional hierarchies are necessary for learning, collaboration, and to optimize patient care (Salehi et al., 2020). Scope of practice limitations coexist alongside hierarchies as another structural safeguard that protects patients but limits autonomy. For example, although RNs without a post-professional APRN degree are not legally allowed to prescribe medications, they are responsible for identifying contraindications, side effects, monitoring the patient, and reporting concerns to the prescribing provider. A registered nurse may administer the medication and monitor the patient for side effects, however, within the nursing hierarchy, they may also rely on licensed practical nurses (LPN) to administer medications, and certified nursing assistants (CNA) to obtain vital signs. Thus, when you consider the single decision point of prescribing and safely administering one medication in the acute care setting, several providers, with varying degrees of scope of practice, must collaborate,

share information, and escalate concerns up the hierarchy, if necessary.

In the above example, the CNA or LPN may ultimately be the provider who observes the hypothetical side-effect (e.g., abnormal vital sign or subjective complaint), which would then be reported to the RN, who would likely assess the patient, contact the prescribing provider, and communicate the outcome. Similarly, a pharmacist may identify a contraindication the prescribing provider may have missed and contact them and/or the registered nurse with an alternate suggestion. Thus, any barrier to communication, whether it be sharing an abnormal lab result, clinical finding, or making a recommendation that optimizes patient care, must be eliminated. In order for healthcare hierarchies to be truly functional, they require healthy relational dynamics (e.g., psychological safety, open communication) between providers because typically several healthcare professionals collaborate on the same decision point and patient care outcome.

Dysfunctional Hierarchies

The inherent power differential between providers who have authority or influence over others can often result in multiple forms of misconduct. For example, Michael, an RN who worked with a physician who was also a notable researcher, reported being coerced into working clinical conferences without pay. He stated, “there was a lot of little things I didn’t like about the way he treated me, but this provider, he wanted me to work on weekends without compensation.” When Michael approached his manager about not wanting to participate, his manager responded as follows:

I'm going to be straight up with you, the doctors, they're the ones that bring in the money, and I need to keep them happy, and if that means you're doing certain extra things and stuff to keep them happy, I'm going ask you to do that.

Prioritizing profits over the wellbeing of healthcare teams was cited as one reason healthcare leaders and managers tolerate misconduct from certain providers. Carol, a nursing manager, shared similar views about allowing misconduct from specialists who generate a lot of revenue. She stated, “Yes, we absolutely allow it especially with what I consider our top earning providers like our heart, vascular, and surgical. Those are the specific teams that I believe there's an allowance for.” Norah, a human resources manager who fields misconduct concerns, described the fear some providers have shared about reporting abusive providers who occupy a higher rank in the clinical hierarchy. She stated:

I work with physicians who are leaders, whether they can have a title or not, folks really feel like there's a different set of rules for them and, "I've had to stand in line, and they have power to talk to my boss and say I'm incompetent, or kick me out of the OR," or all those things.

Another example of how hierarchies give some providers disproportionate power over others was revealed by Sue, a nurse who manages a highly skilled “flex team” of registered nurses who are trained to work in various high-acuity environments. Sue described a surgical team’s influence over the flex team’s work assignments, stating, “They actually came out from the surgical side and deemed their patients would not be appropriate for the flex team because they didn't feel that they were highly skilled enough to take them.”

Ultimately, dysfunctional hierarchies in healthcare result in a decrease in the quality of teamwork through creating barriers to effective communication—and this can have serious relational and clinical consequences. According to Salehi et al. (2020), dysfunctional hierarchies endanger patient safety, undermine physician empathy, hamper learning, lower training satisfaction, and amplifies stress, fatigue, and burnout.” Norah, and HR manager, who fields

misconduct violations for a large health system, stated, “I also think [mistreatment] leads to safety events. I do. I don't think I can draw a direct line to it all the time, but if you're nervous or anxious, it doesn't bring out the best in most people.” Her sentiments were echoed by Joseph, an RN, who shared his perspective on the fear of reporting a medical error has on patient safety, stating, “Mistreatment and blame makes HCPs not want to be honest if they do make another mistake in the future, and just want to cover it up...then, the mistakes will continue to happen, and we're putting patients at risk instead.”

Learner Issues

In academic medicine, functional medical hierarchies aim to optimize patient care through clinical instruction (Salehi et al., 2020). However, when a medical hierarchy becomes dysfunctional, through mistreatment, this has various psychological and cognitive effects on learners, which hinders communication and the quality of teamwork (Hughes & Salas, 2013). In fact, according to Hall and Weaver (2001), medical students internalize hierarchy as early as their undergraduate classes. Through sharing their stories, current medical students and student nurses revealed their exposure to mistreatment during medical/nursing school, which most often began during their clinical practicums. For example, Quentin, a resident physician, reported experiencing incivility prior to residency. He stated, “Incivility starts in medical school, and it was based on my status as a medical student, even before I became a resident.” When speaking about an attending physician who was also a faculty member, Quentin elaborated:

Unfortunately, what I learned from the house staff, other allied healthcare professionals, was at this individual also acted the same way towards other learners when they made some minor mistakes, in terms of the writing orders and stuff, and he was constant yelling about these for about five to 10 minutes with each learner specifically about these

very, sometimes minor mistakes.

However, medical students reported not just being mistreated by physicians, but by other HCPs. For example, Michael, a first-year medical student, described how the medical hierarchy, through limiting his scope of practice, exposed him to degrading behaviors. He stated, “I’ve had nurses say, ‘You’re just a medical student, there’s not much that you can do. I’ll just need to get a real doctor to help.’” Kevin, a student nurse, reported being targeted by a nurse preceptor after making a minor mistake rooming a patient in the emergency department (ED). He stated, “I had already worked overtime and was ready to leave for the night, but this nurse purposely targeted me, berated me about not using critical thinking, and, honestly, I went home and cried the whole night.”

The impact negative learning experiences had on students reinforced a culture where confidence is conflated with competence. Quentin stated, “that’s sort of the expectation of you... If you come off being uncertain, I would say that you would be questioned and probably your overall medical decision making would be questioned, too.” This sentiment was witnessed by Sally, a respiratory therapist, who stated, “you can see sometimes that there’s definitely doctors that make the interns more comfortable [when learning] and you see others that are keeping them on their toes.” Some students reported a learning culture that was too punitive and not supportive enough. For example, Samantha, a student nurse, shared her concerns about a preceptor. She stated, “Safe to say that she was constantly evaluating whether or not you were doing your job right, but not doing any coaching...they refused to teach.”

Systemic Issues That Contribute to Harm

Although workgroup harms are relational issues, requiring at minimum a dyad to exist, they were largely influenced if not exacerbated by systemic issues that afflict healthcare

organizations. Thus, although this study sought to explore individual experiences with mistreatment, the underlying systemic issues that lead to harm could not be overlooked. When HCPs recounted the psychological impact mistreatment had on them it became clear that unrealistic workloads, understaffing, process issues, and role confusion were inextricably linked with mistreatment, burnout, cynicism, and job dissatisfaction. Given the high degree of burnout prevalent among healthcare workers caring for COVID-19 patients, which has disproportionately afflicted female providers, nurses, and residents (Jalili et al., 2021), healthcare leaders must develop strategies that improve both the culture and the dysfunctional structures in healthcare.

Workload Demands

Although HCPs are held in high esteem by the public, politicians, and even government officials—recently having been elevated to the status of “heroes” — the resentment expressed by some of the providers interviewed revealed a disconnect between public perception and reality. For example, prior to the COVID-19 pandemic, a healthcare system had proposed a wage cut on nurse’s salaries, even though publicly they were promoting HCPs in a favorable light. Quentin, a resident physician, shared, “right now our system is proposing a 3% wage cut for our nursing staff, which is meeting a lot of disagreement because a year back, they had just sent out a campaign saying that nurses are our frontline heroes.” The working conditions HCPs and medical students reported revealed the level of psychological stress, clinical pressure, and unfair workload demands they’ve been experiencing.

When describing the impact staffing shortages have had on her unit, Carol, a nursing manager, stated, “Our patient load has stayed the same. We’re still seeing the same number of patients, but with far less people. So, we are still asked to provide the level of care every patient deserves but with less resources.” A concomitant stressor she described was insurance

companies limiting the amount and type of care but expecting the same patient satisfaction scores. Carol elaborated:

It seems like there's so much control by the insurance companies dictating length of stay, what tests can be done. This feels like it's very limiting to us, and now we're all at the mercy of the patient experience. If our patients aren't happy, we're not going to get reimbursed, doesn't matter all the work we put in.

The distress of trying to provide quality patient care while being under-resourced was described by Tracy, an RN, as follows, "This person's life is in my hand. It's my license, it's my livelihood," and so there's added pressure and pressure never brings out the best in anyone."

The dynamic nature of healthcare means that some patients can quickly take a clinical turn for the worse. Thus, for HCPs experiencing burnout or cynicism, the acute stress of dealing with a life-or-death situation (coupled with an already demanding workload), can lead to providers lashing out at each other. Roselyn, a critical care physician, stated, "During those high stress environments, I feel like everyone... even if you try not to, your adrenaline's going, you get on edge, and it's a patient, it's their life." And those dynamics, naturally, spill over into preceptor and training moments, too. Sally, a respiratory therapist, described the tension that comes with precepting a student when the clinical stakes are high. "I think it's human life, so you can't let [students] completely fail because if you let them completely fail, that could be life or death. It's not maybe a slap on the wrist, it's a big thing."

For resident physicians, exposure to long shifts, high acuity patients, and being on call for various departments, can be especially daunting. Quentin, a surgical resident, reflected on a very difficult shift. He stated:

One time when I was on the orthopedics rotation, I had four or five pagers on my person...I had a running list of pages that I had to return with over 100 pages during one night, so it can be certainly in a lot of responsibility, and sometimes as the main medicine resident, you cover all the non-surgical stuff. If an orthopedic patient went into atrial fibrillation, you would be the best person to know what to do because all the orthopedic residents may not have that expertise.

When viewed collectively, the compounding effect of being underappreciated by administration, misunderstood by the public, and the moral distress that accompanies unrealistic workloads, creates the perfect formula for burnout, which not only increases the likelihood of mistreatment but its perceived intensity.

Staffing Issues

In healthcare, highly effective teams have been associated with improved patient care outcomes, namely the quality and safety of patient care (Manser, 2009). However, according to the respondents, the nature of working in a hospital setting can lend itself to inconsistency with staffing, which results in workgroup dynamics that decrease the quality of teamwork. For example, Roselyn, an intensivist, stated, “In the hospital setting, I find it's much harder to collaborate because the teams are often fluctuating and changing, so we often don't know the staff around you.” Like many of the processes that have changed in response to the COVID-19 pandemic, HCPs have been redirected to work in departments that cater to COVID-19 patients, like the ED and ICUs. Furthermore, the use of temporary employees and/or “travelers” have introduced clinicians who are unfamiliar with hospital policies or providers, which has resulted in communication issues, process issues, and inconsistent patient care outcomes.

Roselyn, a physician who has worked in primary care and now works in the hospital setting, said the difference between the two settings comes down to being more familiar with your colleagues and optimizing each other's strengths. She stated:

In primary care for the large part, you work with the same support staff day in and day out, so you get to know people, they get to know you and your expertise and such, even if there's a bad person in that team, you can navigate your way around them and figure out work arounds."

Roger, a traveling nurse who is originally from Alabama, described the orientation process of joining a health system in Southern California as follows:

It's constantly going into new environments, learning how things are done in those clinics, learning the personalities of not just the providers, but also the staff that you're working with, figuring out what your resources are, things like that, and so that can be challenging sometimes, because you don't have a regular team.

Although traveling HCPs have alleviated much of the burden healthcare institutions are facing in response to local staffing shortages, unfortunately, they have also been met with some resentment. For the staff nurses who work with Carol, a nursing manager, the pay differential between staff nurses and travelers is so wide many of the staff nurses decided to leave the organization. Carol stated, "They were very, very resentful. Finally, under this new administration we have starting to feel valued. But we have lost a lot of nurses because they did not feel valued."

At another hospital system in Southern California, the frustration over the perceived prioritization of traveling healthcare workers boiled over to the point of a nursing strike. Roger, and RN who stated most of his co-workers are travelers, stated, "People are voicing their

opinion, the full-time staff, they're going on strike next week. They're saying, how can the hospital afford travelers and not afford to pay full-time staff more money” The tension between house staff and travelers not only created relational conflict, which has tested provider loyalty, but it has created scenarios where travelers are staffing units without being adequately oriented and trained. Roger shared a scenario where a physician lashed out at an entire team of travelers, accusing them of incompetence. He stated, “The doctor started belittling the nurse and travelers all together, like, ‘we have all these travelers coming down here and they don't know what they're doing—we're paying them all this money,’ and she just went on a rant.”

In addition to experiencing financial challenges and interpersonal conflict related to staffing, healthcare managers also reported difficulty recruiting and retaining new graduates. Carol, a nursing manager, shared some of the reasons new graduates ultimately elected not to stay in the profession. She paraphrased some common new graduate RN responses, "Oh, my God. This is a lot.” “We have a very difficult profession because everything boils down to nursing. Nursing encompasses all other disciplines, right?” Clearly, the connection between staffing shortages, unrealistic work demands, and provider burnout has created a perpetual cycle that has resulted in two very concerning scenarios: (1) experienced, skilled nurses are leaving the profession due to burnout, and (2) new graduates are becoming disillusioned and leaving the profession due to organizational dysfunction.

Process Issues

Another systemic challenge that respondents identified as a source of relational conflict was poor process management. When you consider the fact that some physicians and their teams may have hospital privileges but may not be employed by the hospital, there may be unclear expectations of what constitutes a correct process. Similarly, for medical students, nursing

students, and traveling HCPs, quickly familiarizing themselves with policies and procedures, the scope of practice of other practitioners, and the hierarchies of power and decision-making, can result in confusion and frustration. For example, Michael, a medical student, shared what it's like to constantly rotate to a new unit and familiarize yourself with its respective policies, stating, "In the hospital setting, it's much harder because the teams often fluctuate and change, so when the staff don't know you, your skills and what you're allowed to do, it causes a lot of confusion among the nurses."

Role confusion was also cited as a reason some providers became frustrated and lashed out at others. For example, Michael, an RN, described how some providers try to negotiate nursing roles. He shared an exchange he had with a physician: "The doctor said, 'what are your duties here, how are you helping us today?' and I was like, I'm assigned to triage, and she decided that her needs would dictate what role I was assigned to." Another nurse, Tracy, described a similar situation involving a physician assistant. She recounted:

I was taking care of a patient and the PA for another patient popped into the room I was in and said, "I need you to come in here and help me take out the Staples," and I'm like, okay, I'm in the middle of taking care of another patient, who are you to tell me now that I need to stop what I'm doing?

For medical students, whose scope of practice varies depending on where they reside within the academic medicine hierarchy, confusion over their scope of practice was another process issue that reportedly caused frustration. Quentin, a medical resident stated, "Sometimes I think there's a bit of frustration, especially from the discharge coordinators, because understandably, as medical students, there were a lot of things that we couldn't sign off on, in terms of discharge paperwork and such."

In addition to the staffing issues and scope of practice concerns identified, poor interprofessional communication can result in unsatisfactory patient care outcomes, which can lead to workgroup mistreatment. Some examples of this include: a provider running behind schedule, medication delays from the pharmacy, supply issues, and miscommunication between providers and departments, just to name a few. For many of the providers who reported being mistreated, process issues beyond their control were cited as reasons some colleagues lashed out at them. For Carol, an RN who responded to a patient whose behavior was progressively escalating due to being hungry, a miscommunication between the medical team and nursing unit, resulted in violence being directed at the nursing team. She stated:

The poor guy hadn't eaten since yesterday at 9 o'clock or something, he's starving, but where does it come out at? It comes out at the nurse. So, this escalating violent behavior directed at us and yelling and screaming where we couldn't control it. We can get the physicians to come in and talk to him, [which they did for about five minutes] and then they escaped, but the nurse is the one sitting there, tolerating this for 12 hours.

Even for the most experienced clinical providers, when processes vary within healthcare systems, the frustration, confusion, and disappointment that can accompany a variance in patient care can result in horizontal violence. For Tracy, an RN who has worked at two hospitals within the same healthcare system, following a protocol for a Morphine drip that was used at the sister hospital where she previously worked, resulted in her being punished and teased by another nurse. She stated:

The nurse said, we don't do that at this hospital. And she just immediately laid into me like, "That's so dumb, why would you think that...what?... That makes no sense." And then she went and told a couple of the other nurses that were around me, and I just made

a joke of it, just to kind of protect myself.

Tracy's response to having been degraded and teased, which was to release the tension by using a self-deprecation strategy, is one of the psychological strategies HCPs use to cope with mistreatment, which will be discussed in greater detail on page 96.

Finally, a timely example of how an unclear process led to confusion and conflict had to do with communication of clinical protocols for COVID-19. According to Michael, an RN who was working at an outpatient extension of the hospital, "I was blamed for not accompanying a physician who was examining a patient that had COVID-19 symptoms." At the time of the incident, which was early in the COVID-19 pandemic, providers were wary about seeing any patients with cold or flu like symptoms, he reported. However, no clear policies had been established for scheduling patients who had COVID-19 symptoms, the use of personal protective equipment (PPE), and which providers would be helping assess and triage those patients. As a result of the unclear processes, the director of the unit blamed Michael for not supporting the physician. Michael stated:

Because I was the only RN in the clinic, management was like, "Well, you're the RN, you have the license. You should know what to do." And I was like, "Well, COVID is new, we didn't learn about COVID-19 in nursing school," and I asked her to explain the process management, "how do you want us to see patients who may have COVID-19 symptoms?"

Conclusions

HCPs, medical students and nursing students, working in acute-care environments, experience various forms of workgroup mistreatment, which vary from non-verbal forms of incivility to verbal abuse, harassment, bullying, public shaming, and physical abuse.

Additionally, some providers reported identity-based harms (e.g., gender and racial bias), and frank acts of racism and sexism. These harms are nested within much larger cultural dynamics (blame culture, dysfunctional hierarchies, competition, organizational silence) and systemic issues (workloads, process issues, staffing), which were found to be inextricably linked to workgroup mistreatment.

Impact of Workgroup Mistreatment on HCPs and Healthcare Teams

The cumulative effect of experiencing verbal, physical, or identity-based harm, working in highly competitive and “blame” cultures, and enduring the systemic pressures that can both lead to and exacerbate harm, have significant, deleterious effects on: (1) HCPs’ mental health, (2) the quality of communication and teamwork, and (3) job satisfaction/work intentions.

Through using direct quotes from respondents who graciously shared the impact harm and trauma had on them, the three aforementioned themes will be discussed in greater detail.

Mental Health Impact

The psychological toll mistreatment had on the students and HCPs interviewed varied from classic emotional responses to harm or trauma (e.g., anger, sadness, frustration) to cognitive and emotional dissonance, disengagement, and depression. Some providers associated mistreatment, especially character attacks, with having less aptitude than others, which resulted in a diminished sense of self-worth (professional insecurity). As a result, some providers reported working in a persistent state of fear (of degradation or punishment), which contributed to organizational silence and feelings of isolation. Cumulatively, these dynamics contributed to a pernicious cycle of emotional exhaustion, cynicism, and burnout.

Emotional Impact of Mistreatment

Being degraded, harassed, or publicly shamed is often a traumatic experience that elicits a wide range of negative feelings and emotions. Acute responses to mistreatment varied from feelings of fear, anger, frustration to embarrassment, nervousness, distress, and even hopelessness. As has been revealed in previous sections, in the wake of public humiliation, some providers have felt such profound emotional distress they have been moved to tears. For some respondents interviewed, being mistreated resulted in a state of cognitive dissonance, or shock,

which was explained by Michael, an RN, who experienced a racial microaggression. He stated:

I will never forget this moment where I didn't know if there was a name for it, but I remember feeling so uncomfortable and going to my co-worker who was a woman of color and talking to her about what had just happened. She' like, "That's racist. That is not okay."

Learners shared the devastating impact mistreatment can have on the [human spirit], and the willpower needed to pursue a career in healthcare. For example, Tracy, a nurse educator, shared what it's like to support nursing students who have experienced mistreatment in their clinical rotations. When speaking about an incident involving a preceptor who yelled at a student, Tracy stated, "This semester one of my sweet little nursing students, one of her preceptors broke her spirit, so I had to try to build her back up and let her know, 'you're going to be a good nurse one day.'" Kevin, a nursing student who was on a clinical rotation in the ED, was berated by a unit nurse who singled him out and insulted his critical thinking skills. When reflecting on the impact the incident had on him, Kevin recounted, "He made a huge deal about it and just put me down, and to be honest, I never wanted to be a nurse after that...I thought about making it through so many semesters, but in that moment, he knocked me down back to ground zero."

Even for experienced HCPs, the impact of mistreatment can cause ripple effects, which spill over into the home environment. Michael, an RN, stated, "It was difficult for me because I'm a person who, when things like that happen in the workplace, I take it home with me, or it affects the rest of my day, and the rest of my day will just be not great." Tracy, another nurse, shared a similar sentiment about an unresolved harm in healthcare environments. She stated, "Yeah, I've been yelled at by physicians before, and of course, they stick with me because it was

traumatizing for me, I've been yelled at twice and in front of people.” For the physicians, nurses, and therapists interviewed, working in a culture that tolerates and even celebrates unhealthy work conditions, reinforces an attitude that HCPs are expected to develop a “thick skin” and tolerate abuse. Sally, an RT, stated, “I think for the large part, you’re expected to deal with [mistreatment].”

Roselyn, a critical care physician, believes HCPs [who mistreat others] are dealing with unaddressed mental health issues themselves. She stated, “I think there's a lot of really deep mental health issues that need to be addressed amongst people that [mistreat others] because it's not what's in front of us, there's something else going on.” Callie, a respiratory therapist, believes mistreatment is used to mask insecurity, adding, “I don't know if putting on a fake persona by mistreating others is used to make sure you don't see what’s underneath—that you’re actually really scared.” Ultimately, the impact of workgroup mistreatment results in HCPs living with various unresolved emotional and spiritual wounds. At the intrapersonal level, this leads to feelings of anger, hurt, disgust, fear, and betrayal. Furthermore, the degradation that often accompanies hierarchical mistreatment results in some providers feeling inferior, less competent, and less valuable than others.

As it relates to teamwork or interpersonal relationships, these unresolved offenses result in mistrust, fractured relationships, and a deep sense of fear of retribution/future harm. For many students and providers interviewed, the fear of holding an offender accountable was just as much—if not more traumatic— than the original offense. Organizational distrust was attributed to why some harmed providers refuse to speak up or report offenses. Sharon, a human resources manager, described the fear associated with holding an offender accountable:

It does affect them emotionally, and in fact, most of them actually don't want us to do

anything with the information, because they're fearful. They say things like, "I have to work with this person. Are they going to know it's me? Can you keep this confidential? I want to be anonymous." It's full-blown fear. It's almost as if there's more fear with addressing it than with dealing with it.

Finally, for students and providers who reported identity-based harms, this resulted in feelings of isolation, oppression, and marginalization, which often inflamed underlying structural/historical harms such as racism, sexism, and homophobia, just to name a few. Sadly, during the study period one research participant, Roger, a Black RN, experienced an act of anti-Black racism in the operating room. He reported abruptly canceling his travel assignment in Southern California due to racist comments made during a surgical procedure. Fostering a sense of belonging for marginalized and underrepresented healthcare workers and students, who in many ways feel undervalued and neglected, was a major theme that emerged in the student nursing circles.

Professional Insecurity (Self-Doubt)

In order to provide safe and effective care for patients, healthcare professionals must both collaborate effectively and work interdependently within a highly complex and dynamic work environment. This means that any barriers to communication and creativity (across disciplines and hierarchies) must be eliminated. Asking questions, taking risks, sharing ideas, and communicating pertinent clinical information, are examples of behaviors that signal "psychologically safe" healthcare teams. Psychological safety can be further defined as, "being able to show and employ one's self without fear of negative consequences of self-image, status or career" (Kahn 1990, p. 708). However, when learners and HCPs experience mistreatment, particularly when their competence or intelligence is attacked, this can result in professional

insecurity (self-doubt), which diminishes the quality of engagement, agency, honesty, and the quality of interpersonal communication.

Tracy, an ICU nurse, recalled an incident where her intelligence was insulted by a physician while they were rounding in the ICU. She stated, “I felt like I didn't belong. Are you familiar with impostor syndrome? Okay, so I struggle with that a lot. So, I felt like maybe I didn't even belong in that role, I'm not meant to be an ICU nurse.” For Tracy, experiencing self-doubt in an environment that is highly competitive resulted in feelings of isolation and diminished her self-esteem, however, it also affected her ability to communicate with that physician. She elaborated about her fear of asking a clinical question, and how she vetted the question first:

Yeah, our fear of being thought of as being stupid for asking a question. I will ask the question, but I will ask one of the physicians that I'm comfortable with first, and I'll kind of run it past them and if they're, “Oh yeah, that's a legit... That's good that you asked that question,” then I'll proceed.

The competitive nature of healthcare environments also means that providers who have been publicly shamed, blamed for a poor patient care outcome, or whose competency has been questioned, resort to a variety of coping strategies, one of which was shared by Tracy, an RN, who stated, “when mistreatment happens, part of me feels like I have to show them I'm a good nurse and I know my stuff and, so now I have to be a little bit on more of an alert and on top of my game to prove to these people wrong.” Another nurse, Michael, shared how being punished or degraded for making a mistake can lead to dishonesty for fear of being considered incompetent. He stated, “It makes them want to not be honest if they do make another mistake in the future or anything, and just want to cover it...and we're putting patients at risk instead of creating a safe environment of care.”

Living in Fear

The cumulative effect of working in highly competitive environment, where blame or mistreatment is used as a form of punishment and/or social control, results in some HCPs living in a persistent state of fear. If psychological safety creates the conditions where providers can share openly and honestly, without fear of negative consequences, then living in an environment that feels dangerous can lead to several distressing and dysfunctional outcomes. Medical students not feeling psychologically safe enough to offer a clinical suggestion, providers not advocating for a patient for fear of being insulted and damaging their reputation, and nurses not addressing a conflict with a colleague for fear of retribution are all examples of how fear can stymie growth and potential, impact clinical outcomes, and damage interpersonal relationships. This, of course, is amplified in situations where a provider has been mistreated by a colleague but is unwilling to report their offender for fear of retribution. Sometimes the fear is so profound, healthcare professionals would rather remain anonymous, or retract their statements altogether, which was shared by Sharon, an HR manager:

Most of them actually don't want us to do anything with the information, because they're fearful. They say things like, "I have to work with this person. Are they going to know it's me? Can you keep this confidential? I want to be anonymous." It's full-blown fear. It's almost as if there's more fear with addressing it than their dealing with it.

Unfortunately, the consequence of refusing to hold an offender accountable for harm results in a culture that undermines psychological safety and allows mistreatment to go unchecked. Thus, the person harmed never gets their needs met (and continues to live in fear), the person responsible for harm is never truly held accountable (and continues to replicate the harmful behaviors), and the entire system loses out on an opportunity to learn from the

experience and improve the culture (through systems learning). The dangers associated with holding a colleague accountable were reputational (eroding professional image), career-related (being fired or limiting career potential), or climate-related (fear of worsening hostility), and they were largely associated with coexisting concerns that leadership/administration would not only not protect them but punish them further. For institutions that are selective about whom they hold accountable for misconduct, this results in severe organizational distrust, which only amplifies fear among vulnerable providers.

When describing an administrative mishap involving a physician, Michael, an RN, was so fearful administration would not believe his side of the story, he thought he would lose his job. He stated, “I was definitely very scared that [the confusion] was somehow going to fire back on me and that I would be terminated.” Tracy, an RN, recounted an experience when a manager refused to hold a physician accountable for mistreating her. She stated, “At that time, I felt like I was not protected and that she was saying it was okay for the physician to treat me like that.” When she was asked to elaborate on why the manager refused to speak up, Tracy responded, “I don't know. I'm sure there's a level of fear there, too, naturally.” Thus, an interesting paradox emerges where some providers can seemingly get away with egregious misconduct and never get held accountable, while others are so petrified of making (even a minor mistake) they walk on eggshells for fear of being punished or losing their job.

Burnout and Cynicism

The literature has established a clear link between the health professions and burnout, which is an emotional and behavioral impairment that results from the exposure to high levels of occupational stress; and has been described as a combination of three factors: emotional exhaustion, depersonalization, and a lack of sense of personal accomplishment (van Mol et al.,

2015; AHRQ, 2017). Burned out clinicians may express cynicism in uncharacteristic negative behaviors, poor communication with others, and even incivility toward co-workers (Kelly et al., 2021). Working in an unhealthy environment of care, combined with the high levels of occupational stress brought on by COVID-19 pandemic, has amplified the conditions that lead to burnout. In fact, a cross-sectional analysis of nurses found that approximately 31.5% of nurses who had quit their job in 2018, reported leaving because of burnout, and a stressful work environment was cited as the top reason nurses left their jobs (Shah et al., 2021).

More than half of U.S. physicians are experiencing burnout, especially those working in emergency medicine, family medicine, general internal medicine, and neurology (Dyrbye, 2017). Furthermore, medical students experience a higher rate of burnout and depression than similar aged students pursuing other careers (Dyrbye et al. 2016; Rotenstein et al., 2016). HCPs working in acute care environments are more likely to experience secondary traumatic stress (STS), which is sometimes known as compassion fatigue or vicarious trauma. STS can be defined as the stress deriving from helping others who are suffering or who have been traumatized (Orzu et al., 2021). According to Cocker & Joss (2016) the convergence of secondary traumatic stress (STS) and cumulative burnout results in a state of physical and mental exhaustion caused by a depleted ability to cope with one's everyday environment.

Thus, working in an environment wrought with climate issues, including workgroup mistreatment, blame and competitive cultures, and the emotional exhaustion that accompanies the relational and occupational demands of working in healthcare, results in a withering effect that leads to burnout. Carol, a nurse manager, shared her perspective on the effect persistent mistreatment has had on nurses in her unit, and how that leads to a cycle of disengagement and burnout. She stated, "You can see it when it's happening [burnout] and when I can see them

physically becoming tense and start to do a lot of complaining.” The long-term effects of working in an such a dysfunctional environment, however, has significant moral and practical implications, as was shared by Sharon, an HR manager, who stated, “They endure it for years and years and years, and then they become anxious, depressed and then they go out on medical leave and the world comes crashing down.”

For many HCPs who have been working through the COVID-19 pandemic, the world has indeed come crashing down. According to Orru et al. (2021), “the COVID-19 outbreak had an impact on the more frequent direct exposure to the patients’ physical pain, psychological suffering, and death, which increased secondary traumatization in healthcare workers” (p. 11). Carol, a nursing manager succinctly explains the ripple effect of burnout, “When I see burnout here in the hospital you'll have sick calls, which doesn't help the staffing, and then there's the lateral violence, and when someone's not happy, there's subpar patient care.” However, it must be made clear that burnout itself does not lead to mistreatment. Though a burned-out clinician may ultimately resort to mistreating others, the relationship is not causal. Rather, the withering effect of burnout, the depleted ability to cope, coupled with workgroup mistreatment, can certainly push a provider to their breaking point, which was revealed by Tracy, an RN, who revealed:

We're not burned out from taking care of our patients, we are burnt out from just being in this environment of negativity all the time, and that's so sad because you lose some great people that are just done, they just can't, they just can't hang in the environment anymore.

Teamwork and Communication

Although mistreatment has significant deleterious effects on providers’ emotional

wellbeing (leading to professional insecurity, fear, and burnout), an emerging field is exploring the relationship between incivility and cognitive function, which has been precipitated by a recognition that psychological safety in healthcare teams improves healthcare outcomes and patient safety. According to Porath & Erez (2007), the cognitive impact of rudeness/incivility, both through direct and indirect experiences, is harmful to task performance, people's objective cognitive functioning, and creativity. Thus, when you consider the level of collaboration that is required in healthcare environments, especially during medical emergencies and high stakes clinical crises, the combination of psychological fear, self-doubt, and an acute decline in cognitive function, can lead to patient endangerment. Even for witnesses of harm, the psychological and cognitive toll can be substantial. Simply witnessing rudeness tends to reduce observers' performance, creativity, and citizenship behaviors (Porath & Erez (2009).

Within the bounds of this research study, workgroup mistreatment was found to hinder the quality of communication and teamwork, patient care, and learning. Thus, each of these themes will be discussed in greater detail.

Communication Barriers

The clinical hierarchies in healthcare can limit interprofessional communication through structural barriers, however, workgroup mistreatment can amplify this by instilling fear, self-doubt, and mistrust in individuals who have previously been harmed. Not surprisingly, harmed providers relied on avoidance tactics, or vetting clinical concerns with a colleague who was deemed to be "safe," in order to prevent a re-offense. In other instances, where there was no history of misconduct, the clinical hierarchy reinforced unwritten rules of interdisciplinary dialogue. For example, Carol, a nursing manager, recounted, "I have witnessed doctors who will bypass patient care technicians (PCT), even if they are in the patient's room at the bedside, but

will look for the RN for their input, and will not talk directly to the PCT.” Jonathan, an RN, shared an experience with a physician who worked alongside him, but communicated through his supervisor. He stated, “If I wasn’t doing things the way he wanted to, he would tell the clinic manager to tell me instead of him talking to me directly, and it was just a very weird energy.”

These communication barriers, namely circumventing certain providers, not only inhibits collaboration and knowledge sharing, but results in once-removed accounts of feedback (clinical or performance-based), which can slow down processes, inhibit learning, erode trust, and diminish a team’s overall performance. More often, however, refusing to approach a provider or clinical preceptor with a reputation for being hostile can inhibit learning and/or have clinical consequences. Carol, a nursing manager, shared how this dynamic was limiting professional development among new staff members, “Three new grad RNs came to me about this particular employee who they were afraid to approach because they felt like she was talking behind their back, making rude comments, and they didn’t want an argument.”

Seeking clarification on clinical rationale, offering a creative idea, or respectfully disagreeing with a provider on a clinical decision, are all hallmarks of psychologically safe work environments. However, the fear of being degraded or publicly shamed can result in the use of organizational silence, which shuts down critical, interprofessional communication, and has a direct influence on medical decision-making. In nursing units, for example, the prolonged exposure to patients during a twelve-hour shift means nurses have witnessed the patient’s progress, response to medications and therapies, or clinical worsening, just to name a few. Thus, during interdisciplinary rounds, when physicians and other healthcare professionals share information and collaborate on treatment decisions, eliminating the perspective of the nurse would be reckless. Nonetheless, that is exactly what harmed respondents reported, a petrifying

fear of sharing their clinical perspective with individuals who have mistreated them, which was revealed by Kristen, an ICU RN, who stated, “Our fear of being thought of as being stupid for asking a question, I wouldn’t dare! Because I’m afraid, I’m afraid if I challenged what [the physician] said... I don’t know, I just don’t know.”

Impact on Patient Care

Barriers to interprofessional dialogue were largely associated with fears of being blamed for a negative patient care outcome, being degraded publicly, or eroding one’s professional reputation, which was especially troubling for medical and nursing students. Ultimately, this resulted in delays in patient care, poorer clinical outcomes, and lost opportunities (e.g., fine-tuning clinical skills and designing innovative treatment plans). For example, Colin, a resident physician, recounted an experience with an orthopedic fellow who was struggling with a surgical procedure, but refused to call his attending for help:

The fellow was doing a surgery, and we could see that he was struggling. It was an overnight case, and the fellow just couldn’t figure out how to actually reduce the knee fracture. And they spent an hour, two hours hammering, trying to figure it out. The OR staff and I could see that this was going nowhere, but he just kept on trying.

In the above example, the staff surgeon ultimately ended up being called in to finish the case, after several hours of delays. The community fallout this had on the surgical team was described as a combination of unaddressed organizational silence, dissonance, and disappointment. Colin elaborated, “I could see from the fellow that there was a lot of disappointment in himself, however, even as a fellow, you’re still a learner and with complicated cases, you should still feel able to call your staff for support.”

Callie, a respiratory therapist, reported a similar incident involving a resident who refused

to call their attending physician and ask for support on a patient who was critically ill and was quickly deteriorating. She stated, “I’ve seen our residents get nervous about calling their attending. I’ve had patients that I believe are pretty critical, and the team was pushing for certain clinical interventions, but they were scared to make the call, and they were also scared to call the attending.”

Finally, as it relates to patient safety initiatives, communication barriers can be dangerous. When HCPs feel at risk for retribution or blame when reporting a safety incident, the entire system loses out on an opportunity to learn from the event, redesign processes (as appropriate), and disseminate the learning as a harm preventive strategy.

Job Dissatisfaction and Impact on Work Intentions

HCPs who experience persistent mistreatment are more likely to call out sick, reduce their work hours, request to be transferred to a different department, or end up quitting their jobs altogether. Amanda, an HR manager, stated, “We’ve got massive issues in terms of absenteeism, and I do think that’s linked to mistreatment.” For healthcare managers and human resources personnel this creates recruitment and retention issues, which can be costly and time-consuming, but for the house staff burdened with picking up additional shifts or higher acuity workloads, this only exacerbates the conditions that lead to burnout. Sharon, an HR manager, shared, “I currently have a few people asking me to be transferred out of their assigned units. They said, ‘I’ve got a grumpy doctor, so if I go to a different floor, I don’t have to see them anymore.’” Tracy, an ICU RN, stated of the toxic culture in her unit, “I have to say, the average ICU lifetime here is three to five years.”

Several of the HCPs interviewed reported quitting a position due to unhealthy team dynamics or poor leadership. For example, Michael, an RN, stated, “I left one of my positions

because I was having issues with the way that a provider was treating me, but what worse still my manager refused to help me.” Prior to quitting, he reported the issue to his manager, who reportedly told him, “I’m going be straight up with you, the doctors, they’re the ones that bring in the money, and I need to keep them happy.” Recruiting highly skilled clinicians has been problematic for Sharon, and HR recruiter, who stated, “Experienced folks are being selective about where they work and not even applying to work here.” She elaborated about the role work environment plays in recruitment efforts, “there’s three other hospitals in our region that have surgery, so I’m sure we’ve lost folks for that reason, and it’s harder to recruit.”

Even for physicians, the impact of burnout is enough to drive them out of private practice as was shared by Carol, an RN, who stated:

I know a couple of doctors who have left private practice to go work at urgent care centers. Now they don’t have to worry about anything, somebody else is sending them a paycheck. They don’t have to worry about their staff being burned out, or not giving enough time to their patients.

Thus, unless the cycle of mistreatment is interrupted, the organizational impact of job dissatisfaction/turnover will result in a revolving door of staff constantly entering and exiting the organization at the expense of consistent care, provider burnout, and forgoing the development of strong peer relationships and good teamwork.

Current Leadership Response Systems

The findings indicate HCPs experience various forms of workgroup mistreatment, which are nested in several cultural and structural problems that contribute to these harms happening. Furthermore, the data revealed the impact of workgroup harm is significant, affecting harmed providers at emotional, cognitive, and relational levels. This, in turn, affected the likelihood of

burnout, job dissatisfaction/turnover, and diminished the quality of patient care and safety through creating interprofessional communication barriers. Given the negative impact workgroup mistreatment has on individual providers, healthcare teams, and even patients, this section will answer the study's third research question: *In what ways, if any, are healthcare organizations and/or learning institutions responding to workgroup-related harms?* Interrogating the ways institutions responded to reports of misconduct or unhealthy relational dynamics was critical to answer the following questions:

1. Did providers who experienced mistreatment get justice? Were their needs met?
2. Were providers responsible for harm held accountable for mistreatment?
3. Was future harm prevented through systems learning?
4. What cultural or process changes emerged, if applicable?

Leadership in a Vacuum

The first impression respondents expressed regarding accountability for misconduct was a phenomenon where leadership, which was more often labeled “administration,” was a strong, threatening presence, but was also largely invisible and existed in a vacuum. Most providers felt burdened by material demands placed by administration (e.g., workload, process changes, staffing decisions, etc.), however, they did not feel administration's presence at a relational level. In fact, many respondents expressed concerns that what happens behind the scenes, the outcomes of misconduct investigations, were poorly communicated, which led some respondents to question the integrity or fairness of the process. For example, Laura, a physician questioned, “Do you think the manager even did anything about it, do you think they even spoke to this person about what they were doing, sometimes the behavior continues, and nothing changes.” Jonathan, an RN, described the role leadership plays at his institution. He stated, “They're neither helping

nor are they making things worse, they're sort of invisible in the background, I haven't seen any... most of them are not around.”

A discussion about clinical versus non-clinical leaders prompted the following perspective from Carol, a nursing manager, who stated, “I think with leadership roles, depending on if you're a clinician or not, you may not have as much of a front-line perspective, you may not have an understanding of what actually goes on in the hospital.” The sense that hospital administrators are disconnected from the experiences or needs of front-line workers was encapsulated by Michael, an RN, who stated, “I think there needs to be more active participation and having [leadership] be in the department and actually be visible on the floors.” Interestingly, during the early stages of the COVID-19 pandemic, hospital administration was more visible in the clinical wards. Colin, a resident physician, expressed, “hospital administration did check in on their staff a little bit more during COVID-19, but I think that's probably fallen by the wayside as the COVID pandemic has improved.”

Selective Accountability for Misconduct

A combination of factors contributed to unjust accountability systems for workgroup mistreatment in healthcare. According to the respondents interviewed, a paradox of *selective accountability* was expressed, where some providers were constantly living in fear of punitive accountability (or retribution), while others were passively held accountable for their offenses or not at all. Passively holding HCPs accountable for misconduct is a leadership issue that was associated with three primary criteria: (1) hierarchical factors, (2) economic factors, and (3) talent factors. Physicians, nursing managers, charge nurses, and surgeons (e.g., cardiothoracic, orthopedic, and their teams) were cited as the groups who were least likely to be held accountable for workgroup mistreatment. In fact, healthcare leaders were reportedly afraid of

addressing misconduct with these individuals or groups, or they resorted to tactics that either minimized or denied the impact of their offenses.

Hierarchical Factors (Positional Influence)

Residing at the top of the clinical or administrative hierarchy was associated with leadership leniency on issues involving misconduct. For many of the HCPs, human resources professionals and students interviewed, there was a genuine belief that there is a “different set of rules” for physicians, charge nurses and people who have acquired additional seniority within the organization. For HCPs who have experienced workgroup mistreated, the lack of leadership accountability and follow-through has created organizational distrust. Thus, many providers reported living with unresolved harms that have never been reported to leadership because current response systems have demonstrated favoritism. Jonathan, an RN, described how he has become selective of whom he is willing to hold accountable for misconduct:

I think it depends on who's causing the harm, what their position is. If I, as a staff nurse, have complaints or concerns of another staff nurse, I feel like management is more likely to get involved and find fair and equitable solutions to whatever problems we may be having, but if it involves a charge nurse, supervisor, or doctor, I'll just ignore it or try not to take it personally.

Kristen, an ICU RN, echoed those sentiments. Rather than attempting to hold physicians accountable for misconduct, she has become more guarded, stating, “Instead, they get labeled as a difficult physician, they just get a label, but no one does anything about it, and it all goes back to hierarchy, so yeah, you just learn to be careful of those physicians.”

The [mal] adaptations that Jonathan and Kristen described, minimization and hypervigilance, demonstrate a degree of disillusionment and apathy with current response

systems. Additional examples of how tolerance to physician misconduct has become engendered in healthcare settings included minimization of unprofessional behavior. Some examples included, “that’s just the way they are, I just ignore it” and “they matter, and I don’t.” However, in one egregious incident, which will remain anonymous, the emergency department was so disillusioned with leadership’s handling of unprofessional behavior in the OR, they resorted to videorecording shared spaces. Providing physical evidence of misconduct to HR was used as a last resort for the ER team, who were convinced leadership would side with the surgeon because of the positional and influential power he wielded.

Finally, non-physician providers in positions of power, or at higher hierarchical rungs, were also reportedly held to lesser standards for misconduct or shown favoritism by leadership. For example, Michael, an RN, recounted, “A lot of the times, the people who [mistreat] have seniority within the organization, which means they’re less likely to be fired and less likely to receive negative feedback—even from healthcare leaders.” Roger, a traveling RN, disclosed his exasperation with the lack of fairness in conduct investigations. He stated, “The managers are in higher position than you are, so you must be wrong. They matter and you don’t.”

Economic Factors (Financial Influence)

Another variable that contributed to why leadership minimized or refused to hold certain providers accountable for misconduct had to do with economics. Whether this was a physician whose clinical program generated a lot of revenue for the health system, or a notable researcher whose grant funding yielded revenue for the learning institution, or both, permissive accountability was attributed to revenue-generating providers. Being socialized into a culture that favored (revenue-generating) providers over others was explained by Michael, an RN who was asked by his manager to pamper a group of surgeons he worked with, which he felt was entirely

outside the scope of his job description. He stated, “She would ask me to do certain things that were [pampering the physicians], or anything outside my scope, she wanted me to do it was because they bring in the money and they need to be happy.”

Feeling undervalued compared to providers who generate a lot of revenue is an implicit outcome of economic leniency. When Kristen, an RN, asked her supervisor for clarification on why certain providers can get away with misconduct, this is the answer she received: “The feedback I've gotten is because doctors bring in the money or the managers in a higher position than you are.” Carol, a nursing manager, easily identified the teams at her institution who have an unfair “allowance” for misconduct, stating, “What I consider our top earning pieces, like our heart and vascular surgical teams, those are the specific groups that I believe there's an allowance for.” Permissive accountability for surgical teams, in particular, has historically been a problem. Sharon, a human resources manager, shared how leaders typically react to the idea of holding surgeons accountable. She quoted, “Do you know how much money this surgeon brings into the organization, how could we possibly take this up?”

Talent Factors

Given the negative impact mistreatment has on job satisfaction, work intentions and turnover, which was discussed on page 108, it would stand to reason that healthcare leaders would use relational leadership skills to redress misconduct for the sake of retaining employees. However, what emerged instead was permissive accountability for providers whose talents were highly valued by the organization and punitive accountability for providers who could more easily be replaced. Thus, another paradox emerged where the institution’s need to retain talented providers (those whose knowledge and skills were scarce and valuable) diminished the level of accountability used by leadership, which reinforced hierarchical favoritism, driving mistreated

providers (who were perceived as being less valued) away from the organization. Sharon, an HR manager, stated the following about using permissive accountability for talented providers, “There are consequences if a person decides to leave a facility and go work elsewhere. That can be loss in knowledge, loss of skills to the organization, so sometimes we sweep things under the rug.”

Professional development efforts are also a financial investment for healthcare organizations. Thus, some leaders found it difficult to hold providers accountable for misconduct for fear of losing that investment and creating additional staffing constraints. Sharon, an HR manager, shared, “We put a lot of resources into training this person be it a physician or a nurse.” Healthcare leaders also used workload and talent contributions as a way of justifying passive accountability. For example, a disruptive employee who works extra shifts is prioritized over providers who are good organizational citizens. Carol, a nursing manager, stated, “If the person picks up a lot of extra shifts, as a manager, they're gold to me.” Sharon, an HR manager, elaborated on the complacency she has observed, stating:

They're a good, fill in the blank. They're a great, fill in the blank. And because their clinical skills are so superior, I've heard things like, "Well, that's just who they are, and they should just ignore it." Again, it's leadership not really saying, "It doesn't matter who is doing this. It's never okay.”

Punitive Response Systems

When healthcare leaders did actively address workgroup mistreatment or climate concerns, their responses were usually punitive. Some providers reported being asked to sign a written disciplinary action form (write-up) or agree to disciplinary decisions (e.g., suspension) without having had a conversation about the incident with their supervisor and/or the harmed

party. Thus, providers who had experienced mistreatment were fearful of reporting the offenses to their supervisors because passive accountability and favoritism could result in retaliation or even termination of employment. Kristen, an RN, stated, “I was definitely very scared that [reporting mistreatment] was somehow going to fire back on me and that I would be terminated.” Therefore, the lion’s share of the providers interviewed for this study refused to seek redress for workgroup mistreatment because they had a lack of trust in their manager’s ability to handle the conduct violation in an unbiased, fair, and equitable manner.

Having to face an individual who was given leniency on a misconduct violation was even more distressing than reporting the original offense. Sharon, an HR manager, reiterated the petrifying fear some providers navigate as they negotiate the pros and cons of holding another provider accountable for harm. She stated, “They say things like, ‘I have to work with this person. Are they going to know it's me? I want to be anonymous.’ It's full-blown fear. It's almost as if there's more fear with addressing it than them [tolerating mistreatment].

When providers who have caused harm are removed from the workplace, through suspension, the harmed parties typically breathe a temporary sigh of relief. However, the punitive models used in healthcare, which usually discourage contact between the harmed party and the offender, leave a lot of needs unresolved. For the harmed party, learning more about the dynamics that led to harm, being able to share the impact of harm, having their harm acknowledged, receiving an apology, and having opportunities to rebuild trust, forgive, and find closure, are missed. For the person responsible for harm, understanding the impact their behavior had on others, acknowledging and/or apologizing for the harm, repairing the harm (making things right to the best of their abilities), rebuilding trust, and preventing future harm, are also missed. For healthcare leaders, being able to support their staff through reinforcing and

embodying institutional values, better understanding the cultural and structural issues that may be contributing to harm, improving communication and teamwork, and preventing future harm through systems learning, are also missed.

Thus, punitive models, like suspension, literally suspend the conflict at hand temporarily rather than resolve it. In fact, healthcare workers reported feeling anxiety knowing the suspended colleague would eventually return to the workplace. Sharon stated, “In some cases, just the fact that we put a provider on a suspension, immediately makes [the harmed party] feel good, but then they're anxious if they know the provider is coming back.”

Support Systems

When asked to describe the factors that protected their wellbeing, or helped them deal with unhealthy work environments, HCPs relied less on leaders and more on their peers for emotional support. A handful relied on meditation and family support to help assuage the impact of mistreatment outside of the workplace. However, collegial support, through establishing strong emotional connections built on trust, kindness, openness, and mutual respect, were largely associated with increased resilience. One example came from the pediatric intensive care unit (PICU), which uses psychological debriefing sessions to unpack the emotional distress that accompanies a pediatric emergency. There, staff members at all levels of the hierarchy, were able to openly express the impact a negative health outcome had on them personally, and what could be done in the future to improve the process. Colin, a resident physician, shared:

I think Peds ICU does a very, very good job in taking care of the people that work there. In terms of debrief, they understand the power of that in terms of teamwork, in terms of improving codes going forward, and improving the staff's overall emotions.

Callie, a respiratory therapist, shared her desire to have additional opportunities to debrief as a team, stating, “I think I would be much more worthwhile if we had more debrief sessions like that. Even when it doesn't have to be a critical event or passing away, but every couple of weeks just to debrief about what had gone by.”

An unprecedented increase in collegial support emerged during the beginning of the COVID-19 pandemic, which was less focused on clinical decision-making, and more on mutual understanding and collaboration. Laura, a critical care physician, stated, “During the beginning of [COVID-19] there was certainly a notion that we can get through this together as a team, and I think there was an increased collaboration and understanding that to get through this, we would need to collaborate.” HCPs also leaned into social support strategies when the looming threat of the poorly understood Coronavirus threatened their collective safety. Colin, a physician who was a resident at the time, stated, “There was certainly a lot of anxiety but also a lot of supportive discussions between staff, and very frank conversations about what this may look like for ourselves, for our families.”

Finally, administration's presence on the medical floors also increased at the beginning of the pandemic, however, their supportive engagement was short lived. Michael, an MD, described the following, “to a certain extent, hospital administrative staff did check in on their staff a little bit more during COVID, but I think that's probably fallen a little bit more by the wayside as the pandemic has improved.” Interestingly, although clinical workloads increased at the height of the pandemic, physician kindness reportedly increased, as was shared by Kristen:

You know what's strange? Once COVID hit our unit, our physicians were nicer because they could see that we the nurses, the respiratory therapists, are the ones that are going into the rooms all the time, and they suddenly became incredibly grateful for us buying

lunch, all those types of things. I guess that contradicts that saying that when we're busier, we're rude, but in this case, they haven't been... They've been a lot kinder during this time.

Conclusions

Current leadership and HR response systems in healthcare discourage the reporting of workgroup mistreatment through acts of omission, minimization, and through exercising selective (biased) accountability. When you consider the combination of blame culture, leadership's clinical absence, nebulous reporting systems, and the fear of retribution, it is no wonder workgroup mistreatment in healthcare pervades and goes unaddressed. As a result, HCPs who have been mistreated are living with various unresolved harms and unmet needs, which have intrapersonal, relational, and clinical consequences. Furthermore, the lack of faith in healthcare leaders holding certain offenders accountable for mistreatment means workgroup mistreatment often goes underreported.

For those HCPs who do seek redress, the current punitive models often backfire on them, through retribution and retaliation, which results in additional harm and distress, which compounds fear and organizational distrust. In other cases, the leadership response is transactional, where disciplinary action is taken based on one-sided (biased) accounts, rather than using dialogical, multi-partial investigations that seek to understand multiple perspectives. In more egregious cases, where leadership has no other choice but to respond punitively, the offender is typically separated from the workplace. However, this, too, results in missed opportunities to use relational leadership skills in order to repair the harm, rebuild trust, and prevent future harm.

Thus, certain providers responsible for causing harm are not truly held accountable for mistreating their colleagues, and through using passive accountability, healthcare leaders continue to reinforce hierarchical favoritism, which socializes all parties into a culture that values some providers more than others. Sadly, this creates the conditions that lead to abuses of power, dysfunctional hierarchies, poor communication, and poor teamwork—which trickles all the way down to the patient care level. Interrupting these dysfunctional patterns will require courageous acts from leadership, namely a combination of supportive leadership skills (restorative component) and unbiased accountability for poor organizational citizenship (accountability component).

QUANTITATIVE FINDINGS

To answer the study's fourth research question: *In what ways, if any, do HCPs or learners benefit from restorative practices to deal with workgroup-related harms?* The study evaluated two RJ interventions in the following settings: academic medicine and academic nursing. The following vignettes include a short case study, the goals of the intervention, and the quantitative findings that emerged.

RJ in Academic Nursing (RJAN)

Background

The University of San Diego's Hahn School of Nursing offers a Master's Entry Program in Nursing (MEPN), which is a twenty-one-month, post-baccalaureate nursing program in Southern California. The MEPN program provides students with a general foundation in nursing as well as master's level courses in leadership, health equity, and administration. The Fall/2020 cohort, which consisted of 53 nursing students, started the program during the peak of the COVID-19 pandemic, thus, they were forced to attend classes remotely through the Zoom virtual learning platform. As a result, the students did not have the opportunity to establish interpersonal connections, friendships, and support systems in the same way previous in-person cohorts had. As the program progressed, the virtual learning restrictions were lifted, and the students eventually convened in-person in 2021, which is also when they started their clinical internships.

During their clinical rotations at area hospitals, several students reported being exposed to workgroup mistreatment (e.g., bullying, degradation, verbal abuse), which was largely due to hierarchical factors and a culture that wasn't always welcoming of students. Other students witnessed implicit bias and stigma against patients, for which they felt powerless to speak up. This resulted in a compounding effect, where these climate concerns were coupled with the

emotional stress that accompanied learning nursing skills during an emergent and dynamic pandemic. The climate within the cohort was tense, since the students did not really know each other well, and many reported feeling isolated and emotionally disconnected from their peers. Furthermore, the culture within the program was also reportedly quite competitive.

The RJ Intervention

The Center for RJ at the University of San Diego offers both graduate-level and professional-level certificates in RJ facilitation and leadership. The three-course program deepens students' understanding of RJ philosophy and practices and incorporates several skill-building practicums, including designing and facilitating restorative circles and conferences. Through identifying a shared interest in redressing campus and clinical climate concerns in a prosocial, equitable and supportive manner, Dr. Bridget Frese, PhD, PHN, CNL, CNM, clinical associate professor at the Hahn School of Nursing, and Pedro Flores, MAS, RRT, PhD candidate, an RJ facilitator and trainer, enlisted the support of Dr. Justine Andreu Darling, PhD, co-director of the certificate in RJ facilitation and leadership at USD.

Thus, a serendipitous opportunity for collaboration ensued between the Hahn School of Nursing and the Center for RJ, with the goal of using community building circles to build and strengthen relationships within the student nursing cohort and to reinforce learning about implicit bias through storytelling. A total of five RJ practitioners, who completed the certificate program in RJ facilitation and leadership, simultaneously co-facilitated six in-person community building circles (mean of 8-9 students per circle), which were held on campus on November 17, 2021, at the Hahn School of Nursing. Refer to Appendix E for the circle protocol.

Goals of the RJ Intervention

- Teach the nursing students about RJ principles and implicit bias in healthcare

- Use community building circles to build and strengthen relationships within the cohort
- Share the impact, if any, of mistreatment, implicit bias in healthcare, or climate concerns within the nursing program or the clinical setting
- Use RJ action plans to prevent biased nursing in the future
- Explore how the RJ philosophy can help address interpersonal conflict in the future

Quantitative Findings

A total of 34 of 53 students (64% response rate) completed an online survey, which was available immediately after the circle experiences via the Qualtrics survey platform. The survey window was open from November 17, 2021 through December 6, 2021. The demographic distribution of the survey participants revealed most of the respondents were female (91%), 70% of whom were between 25-34 years old, and most respondents identified as White (45%), followed by Latinx/Hispanic (30%), Asian American Pacific Islander (AAPI; 15%), Black (3%), Native American (3%), and Other (3%).

In addition to measuring demographic characteristics, the questionnaire asked the nursing students to self-report their beliefs, opinions, expectations, and experiences with the circle process (Neuman, 2011). Therefore, the primary theoretical constructs the instrument sought to measure were RJ's ability to:

1. Build and strengthen relationships (through storytelling and ceremony)
2. Create an equitable and inclusive (non-hierarchical) dialogue space
3. Improve group relations (with the goal of improving the climate)
4. Align RJ relational practices with the values that underpin healthcare
5. Improve relational intentions (after experiencing RJ)

Results

Table 4*Quantitative Findings RJAN*

Operational Construct	Question	Results
Ceremony's influence on authenticity (fidelity to circle process)	Q1 - The structure of the circle created a space for dialogue that helped me share more authentically.	100% agree
Mindfulness	Q2 - The circle experience helped me disconnect from other distractions.	97% agree
Emotional connection with peers	Q3 - The circle experience made me feel more connected to my peers/colleagues.	100% agree
Emotional connection with institution	Q4 - The circle experience made me feel more connected to the institution where the circle was held.	58% agree
Strengthening relationships	Q5 - As a result of the circle experience, I believe the relationships between the circle participants will become stronger.	97% agree
Equitable Dialogue	Q6 - The circle experience created an environment for dialogue where everyone's perspective mattered.	100% agree
Flattening Hierarchies	Q7 - Circles are a good venue for discussing difficult issues across multiple positional levels (e.g., faculty, staff, student).	92% agree *Nursing faculty did not participate in the circles.
Elevating Marginalized Voices	Q8 - In the circle, people who don't usually have a voice had a chance to authentically share their perspectives.	94% agree
Mutual understanding of complex phenomena and lived experiences	Q9 - I believe circles can help me learn multiple perspectives.	97% agree
Increasing empathy	Q10 - I believe circles can help me increase empathy.	97% agree

Reducing judgment	Q11 - I believe circles can help me reduce judgment.	97% agree
Reducing blame	Q12 - I believe circles can help me reduce blame.	97% agree
Improving psychological safety	Q13 - I believe circles may promote psychological safety while discussing difficult issues.	100% agree
Addressing conflict	Q14 - In the circle, we were able to discuss difficult issues (e.g., learner mistreatment, implicit bias in healthcare) openly and honestly.	100% agree
Collaboration/Action Planning	Q15 - In the circle, we were able to create action plans/solutions for difficult issues (e.g., learner mistreatment, implicit bias in healthcare).	94% agree
RJ Aligns with institutional values	Q16 - I believe circles are a radical departure from what we usually do and more aligned with the values that have been established at this institution.	68% agree
RJ helps create a just and learning culture	Q17 - I believe circles are a radical departure from what we usually do and more aligned with the institution's goals of creating a just and learning culture.	79% agree
RJ aligns with healthcare values	Q18 - I believe circles are a radical departure from what we usually do and more aligned with the values that underpin healthcare.	91% agree
Deepen relationships	Q19 - Based on my experience in the circle, I would be more willing to get to know my colleagues better.	88% agree
Improving climate (work environment)	Q20 - Based on my experience in the circle, I would be more willing to actively work toward a more	82% agree

	collegial work/learning environment.	
Use RJ to solve problems	Q21 - Based on my experience in the circle, I would be more willing to work through a difficult team issue using circles.	79% agree
Use RJ as a leadership strategy	Q22 - Based on my experience in the circle, I would be more willing to use restorative circles as a leadership strategy.	88% agree
Change my perspective & deepen relationships	Q23 - For this question, reflect on a person or persons in your circle you didn't know well or get along with. After the circle, rate your willingness to improve your relationship with them (transtheoretical model of change)	<ul style="list-style-type: none"> • 75% yes • 22% after more planning • 3% maybe
Build & Strengthen Relationships	Q24 - Based on my experience with circles, I believe RJ helps create deeper, more meaningful relationships between colleagues.	94% agree
Create Diverse, Equitable, and Inclusive (DEI) work environments	Q25 - Based on my experience with circles, I believe RJ helps create more diverse, equitable, and inclusive (DEI) work/learning environments.	94% agree
Improve the climate in healthcare/learning environments?	Q26 - Based on my experience with circles, I believe RJ helps improve the climate in healthcare/nursing education settings.	94% agree
Transferability of RJ to healthcare and academic learning settings?	Q27 - I think the institution where the circle was held would benefit from additional RJ implementation.	100% agree

RJ in Academic Medicine (RJAM)

Background

Pacific Northwest University of Health Sciences (PNWU), which is located in Yakima, Washington, offers a four-year post-baccalaureate osteopathic physician program (DO) through the college of Osteopathic Medicine. Dr. Mirna Ramos-Diaz, MD, MA, FAAP, the chief diversity and inclusion officer and associate professor of pediatrics at PNWU, became interested in the RJ philosophy through her affiliation with AAMC. After completing the certificate in RJ facilitation and leadership at USD, Dr. Ramos-Diaz began incorporating community building circles at PNWU during new student orientation. However, this later expanded to a much larger initiative, which included using circles to reinforce DEI pedagogy in medicine, respond to social conflict (e.g., Texas abortion ban), and to build capacity through training faculty and staff in RJ. Finally, circles were used to reinforce PNWU's Roots to Wings program, which is a co-mentoring health sciences education pathway program for local Native American and Mexican American students in grades six through twelve.

Building Capacity for RJ

A total of 21 students, faculty and staff members were trained in circle facilitation by an independent RJ consultant, Toni McMurphy, who specializes in healthcare and academic medicine. Between August 11, 2021 and December 8, 2021, the PNWU RJ team facilitated a total of ten in-person community building circles, which were held on campus at PNWU and attended by approximately 280 medical students. The first four circles were facilitated by a combination of faculty, staff and students, however, the medical students eventually began facilitating the circles on their own. Of central importance to ensuring students felt supported and psychologically safe in the circle space, the PNWU team honored the students' request to not

integrate faculty and administration in the circles due to their inherent power differentials. Refer to Appendix F for the community building circle protocol that was used.

Goals of the RJ Intervention

- Building strong relationships with each other,
- Developing the skills to address difficult conversations,
- Decrease implicit bias in healthcare, and
- Improve the quality of their relationships through establishing emotional connections.

Quantitative Findings

A total of 53 of 280 students (19% response rate) completed an online survey, which was administered via the SurveyMonkey platform. The survey window was open from January 14, 2022 through February 14, 2022, which was nearly six months after the first circle experience. The demographic distribution of the survey participants revealed that most of the respondents were female (57%), 77% of whom were between 22-30 years old, and most respondents identified as White (55%), followed by Asian American Pacific Islander (AAPI; 28%), Latinx (6%), Black (4%), Native American (2%), and Other (4%).

Results

Table 5

Quantitative Findings RJAM

Operational Construct	Question	Results
Ceremony's influence on authenticity (fidelity to circle process)	Q1 - The structure of the circle created a space for dialogue that helped me share more authentically.	91% agree
Mindfulness	Q2 - The circle experience helped me disconnect from other distractions.	94% agree

Emotional connection with peers	Q3 - The circle experience made me feel more connected to my peers/colleagues.	94%
Emotional connection with institution	Q4 - The circle experience made me feel more connected to the institution where the circle was held.	68% agree
Strengthening relationships	Q5 - As a result of the circle experience, I believe the relationships between the circle participants will become stronger.	81% agree
Equitable Dialogue	Q6 - The circle experience created an environment for dialogue where everyone's perspective mattered.	99% agree
Flattening Hierarchies	Q7 - Circles are a good venue for discussing difficult issues across multiple positional levels (e.g., faculty, staff, student).	77% agree *Academic medicine faculty did not participate in the circles.
Elevating Marginalized Voices	Q8 - In the circle, people who don't usually have a voice had a chance to authentically share their perspectives.	89% agree
Mutual understanding of complex phenomena and lived experiences	Q9 - I believe circles can help me learn multiple perspectives.	94% agree
Increasing empathy	Q10 - I believe circles can help me increase empathy.	89% agree
Reducing judgment	Q11 - I believe circles can help me reduce judgment.	89% agree
Reducing blame	Q12 - I believe circles can help me reduce blame.	89% agree
Improving psychological safety	Q13 - I believe circles may promote psychological safety while discussing difficult issues.	85% agree
Addressing conflict	Q14 - In the circle, we were able to discuss difficult issues (e.g., learner mistreatment,	87% agree

	implicit bias in healthcare) openly and honestly.	
Collaboration/Action Planning	Q15 - In the circle, we were able to create action plans/solutions for difficult issues (e.g., learner mistreatment, implicit bias in healthcare).	N/A
RJ Aligns with institutional values	Q16 - I believe circles are a radical departure from what we usually do and more aligned with the values that have been established at this institution.	87% agree
RJ helps create a just and learning culture	Q17 - I believe circles are a radical departure from what we usually do and more aligned with the institution's goals of creating a just and learning culture.	89% agree
RJ aligns with healthcare values	Q18 - I believe circles are a radical departure from what we usually do and more aligned with the values that underpin healthcare.	74% agree
Deepen relationships	Q19 - Based on my experience in the circle, I would be more willing to get to know my colleagues better.	91% agree
Improving climate (work environment)	Q20 - Based on my experience in the circle, I would be more willing to actively work toward a more collegial work/learning environment.	91% agree
Use RJ to solve problems	Q21 - Based on my experience in the circle, I would be more willing to work through a difficult team issue using circles.	89% agree
Use RJ as a leadership strategy	Q22 - Based on my experience in the circle, I would be more willing to use restorative circles as a leadership strategy.	N/A * This cohort was not asked this question.
Change my perspective & deepen relationships	Q23 - For this question, reflect on a person or persons in your circle you didn't know well or get along with. After the circle,	N/A * This cohort was not asked this question.

	rate your willingness to improve your relationship with them (transtheoretical model of change)	
Build & Strengthen Relationships	Q24 - Based on my experience with circles, I believe RJ helps create deeper, more meaningful relationships between colleagues.	85% agree
Create Diverse, Equitable, and Inclusive (DEI) work environments	Q25 - Based on my experience with circles, I believe RJ helps create more diverse, equitable, and inclusive (DEI) work/learning environments.	89% agree
Improve the climate in healthcare/learning environments?	Q26 - Based on my experience with circles, I believe RJ helps improve the climate in healthcare/nursing education settings.	94% agree
Transferability of RJ to healthcare and academic learning settings?	Q27 - I think the institution where the circle was held would benefit from additional RJ implementation.	89% agree

Quantitative Data Analysis

Fostering Authenticity and Connection

Based on the quantitative findings that emerged, it is clear that restorative practices, namely community building circles, are an extremely effective way of building strong, interpersonal relationships between students in academic medicine and academic nursing settings. Beginning with the structural and ceremonial components of the circle process, which included circular seating, a centerpiece, the use of a talking piece, an opening reading (land acknowledgement), a mindfulness moment (breathing exercise) and consensus on community agreements, an environment was created where students could be present, mindful, and vulnerable. In fact, 97% of student nurses and 94% of student doctors believe circles helped them disconnect from other distractions and 100% of student nurses and 91% of student doctors

believe the structure of the circle created a space for dialogue that helped them share more authentically.

Building and Strengthening Relationships

Through using storytelling prompts that queried their journey towards pursuing a career in healthcare, the students engaged deeply in learning about each other's lived experiences, which had two powerful socioemotional benefits: (1) realizing how interconnected their lives were, which facilitated closeness, and (2) learning new information about each other, which profoundly changed their perspectives. Remarkably, 97% of student nurses and 94% of student doctors believe circles helped them learn multiple perspectives. Furthermore, 100% of student nurses and 94% of student doctors felt more connected to their peers after the circle experience. Consequently, 94% of student nurses and 85% of student doctors believe RJ helps create deeper, more meaningful relationships between colleagues.

Fostering a Sense of Belonging

The community building circles process proved to be an effective way of fostering Diverse, Equitable, and Inclusive (DEI) learning environments. By seating everyone in a circle, where they were facing each other, hierarchical structures that typically create power imbalances were eliminated. Equitable dialogue was achieved by using a talking piece, which helped elevate marginalized voices. Thus, 100% of student nurses and 99% of student doctors believe the circle experience created an environment for dialogue where everyone's perspective mattered. Furthermore, 94% of student nurses and 89% of student doctors believe people who don't usually have a voice had a chance to authentically share their perspectives. Although the circles were not integrated with faculty and staff, 92% of student nurses still believe circles are a good venue for discussing difficult issues across multiple positional levels (e.g., faculty, staff, student),

a finding that reveals RJs potential to improve dysfunctional hierarchies in healthcare environments. Finally, 94% of student nurses and 89% of student doctors believe RJ helps create more diverse, equitable, and inclusive (DEI) work/learning environments.

Addressing Climate Concerns

The circles were also successfully used to address climate concerns the students may have been facing in the clinical setting or learning environments (e.g., bullying, mistreatment), and to discuss sensitive issues in healthcare (e.g., racism in healthcare, implicit bias). The findings revealed the circle environment promotes a level of psychological safety necessary to have difficult conversations while maintaining respectful, non-violent dialogue. In fact, 100% of student nurses and 85% of medical students believe circles promote psychological safety while discussing difficult issues. Through creating a strong enough psychological container to support difficult and often painful dialogue, 100% of student nurses and 87% of student doctors believe they were able to discuss difficult issues (e.g., learner mistreatment, implicit bias in healthcare) openly and honestly.

The final prompt, which took a harm prevention approach, required students collaborate on action plans for preventing implicit bias and improving the climate in healthcare. Given the importance of creating healthy, functional workgroups in healthcare settings (improving teamwork), the findings revealed significant interpersonal benefits. In fact, 97% of student nurses and 89% of student doctors believe circles helped them increase empathy, reduce judgment, and reduce blame. As a result, 94% of student nurses were able to create action plans/solutions for difficult issues in healthcare/learning environments. Finally, 94% of student nurses and student doctors, respectively, believe RJ helps improve the climate in healthcare, academic medicine, and academic nursing settings.

Alignment of RJ Values with Healthcare Values & Goals

Though institutional climate was not measured explicitly, by defining the RJ circle experience as a marker for good climate, or espoused values in action, the gap between RJ values and the institution's enacted values represents a restorative opportunity. When asked to rate the alignment of restorative values with institutional values, the student nursing cohort revealed a significant gap, which may be a latent indicator of poor climate within the nursing program. In fact, only 68% of student nurses believe circles are more aligned with the values that have been established at USD. However, remarkably, 100% of student nurses think USD would benefit from additional RJ implementation.

In the medical school cohort, the alignment of RJ values and institutional values was 19% better than the student nursing group, and 89% of medical students think PNWU would benefit from additional RJ implementation. When asked if RJ aligned with the goal of improving the learning culture in medical and nursing school settings specifically, 79% of student nurses and 89% of student doctors believe circles are more aligned with the goals of creating a just and learning culture. Finally, 91% of student nurses and 74% of student doctors believe circles are more aligned with the values that underpin healthcare.

Improving Relational Intentions

Cumulatively, the circle experience resulted in numerous socioemotional and relational benefits. Through creating an inclusive environment where everyone's perspective mattered, the students were able to be vulnerable and share authentically, which resulted in the formation of strong interpersonal connections. Through the use of storytelling, students both revealed and witnessed details of each other's lived experiences, which fostered interconnectedness, mutual understanding, and resulted in increased ratings of empathy. As a result, difficult and often

controversial conversations could be had in a psychologically safe space, which resulted in a reduction in ratings of judgment and blame.

The transformational experience resulted in 97% of the student nurses and 81% of the student doctors believing the relationships between circle participants will become stronger. Furthermore, based on their experiences in circle, 88% of student nurses and 91% of student doctors would be more willing to get to know their colleagues better. Finally, within the nursing cohort, a promising transformational finding emerged. After reflecting on a person in their circle who they did not know well or get along with, 75% of student nurses would be willing to improve their relationship with them, and an additional 22% would be willing to with more planning/preparation.

These findings demonstrate RJs unique capacity to positively transform the quality of interpersonal relationships, which has significant implications for interpersonal healing. If these same findings carry over into healthcare environments, *the willingness to improve workgroup relationships*, then circles can have a profound impact on healing fractured relationships, which can concomitantly improve teamwork, job satisfaction, and work intentions.

Conclusions

Based on these statistical findings, it is clear that restorative practices, namely community building and climate circles, are an extremely effective way of building and strengthening relationships in medical learning settings. Additionally, the structural and ceremonial components of circles helped reinforce DEI efforts by flattening hierarchies, creating equitable dialogue, and fostering intercultural communication. Furthermore, through creating psychological safety, climate concerns (e.g., mistreatment, injustices in healthcare) were effectively addressed and mitigated through an improvement in workgroup relations (teamwork).

The cumulative effect of circles was a positive improvement in relationship intentions, meaning participants would be willing to actively work toward a more collegial work/learning environment. These findings have significant implications for improving healthcare provider wellbeing, the quality of teamwork, patient care outcomes, job satisfaction and work intentions in healthcare settings.

Finally, when you consider there was a nearly six-month time difference in data collection procedures between the two RJ interventions, the findings proved to be statistically similar nonetheless. This encouraging finding demonstrates the impact of the RJAM intervention was long-lasting, which is particularly important as it relates to maintaining a healthy climate.

CHAPTER FIVE

ANALYSIS

A Restorative Justice Imperative in Healthcare

There is sufficient evidence to conclude that today's HCPs, medical students, and student nurses are experiencing persistent, widespread, and often unaddressed workgroup mistreatment that stems from various cultural, structural, and leadership dysfunctions that allow these harms to pervade. This research study has identified verbal and non-verbal forms of incivility, frank verbal abuse, physical violence, and identity-based harms as the main forms of mistreatment reported. The psychological impact of mistreatment resulted in emotional exhaustion, professional insecurity, and living in a state of fear, which lead an already embattled healthcare workforce through a pernicious cycle that leads to and exacerbates burnout. The organizational impact is significant, resulting in deleterious effects on HCPs' mental health, job satisfaction, and the quality of communication and teamwork—which ultimately decreases the quality of patient care and undermines patient safety.

The underlying cultural components: blame culture, competitiveness, dysfunctional hierarchies, and organizational silence, are the social doctrines emerging practitioners are socialized into. For medical students and nursing students alike, the hyper-focused hierarchical dimension, and the role it plays in academic success, psychological safety, residency and job prospects, is a major restraining force that creates undue anxiety and normalizes dysfunctional behaviors even before clinical experiences begin. Once exposed to clinical externships, clerkships, and residencies, learners begin to experience mistreatment due to dysfunctional academic and clinical hierarchies, and ill-prepared preceptors. Furthermore, for providers already in the system, leadership's tolerance to intimidating and disruptive behaviors, through acts of

minimization, favoritism, passive accountability, and their own discomfort using relational leadership to hold offenders accountable, only reinforces the status quo, thereby normalizing mistreatment, and consequently creating a paradox where some providers (those with less authority and influence are managed punitively, and others (those with more authority or influence) are passively held accountable for harm or not at all.

The structural components that perpetuate harm, specifically the unrealistic workloads, understaffing, and process issues, were also inextricably linked to mistreatment. Thus, the economic forces at play that govern the way healthcare is financed and organized, including the volume of procedures scheduled, nurse-to-patient ratios, pay-for-performance incentives, and any other workload demands that lead to burnout must also be examined and resolved. Bridging the relational divide between staff nurses and travelers, creating consistency in organizational processes, role clarity, and interdepartmental dialogue on how to best improve quality and safety must also be attended to. Therefore, although RJ offers opportunities for inclusive, equitable dialogue aimed at improving the culture in healthcare, it will not work unless the underlying organizational structures and systems are also improved. Thankfully, RJ offers useful tools for collaboration and action planning on process issues and change management

Therefore, it is clear and evident that current leadership and HR response systems for workgroup mistreatment in acute care settings are insufficiently addressing employee misconduct. Through prioritizing economics over employee wellness, using selective accountability on conduct violations, fears of holding certain providers accountable, enabling dysfunctional hierarchies, and a glaring lack of relational leadership skills (supportive leadership behaviors), The unmet needs create a clear *leadership imperative* to implement RJ in healthcare settings for the following reasons:

1. Preventing workgroup mistreatment by building and strengthening peer relationships using a values-based framework,
2. Engendering a culture of civility, respect, and compassion toward HCPs,
3. Responding to harm and conflict in a meaningful, multi-partial way; by creating the conditions for active accountability for mistreatment and developing the relational skills required to repair harm, rebuilding trust, and foster relational healing,
4. Effectively using hierarchies as a teaching/mentoring strategy, not as a form of punishment and social control, and
5. Promoting psychological safety with the goals of improving the quality of communication and teamwork, thereby ensuring the best possible patient care outcomes.

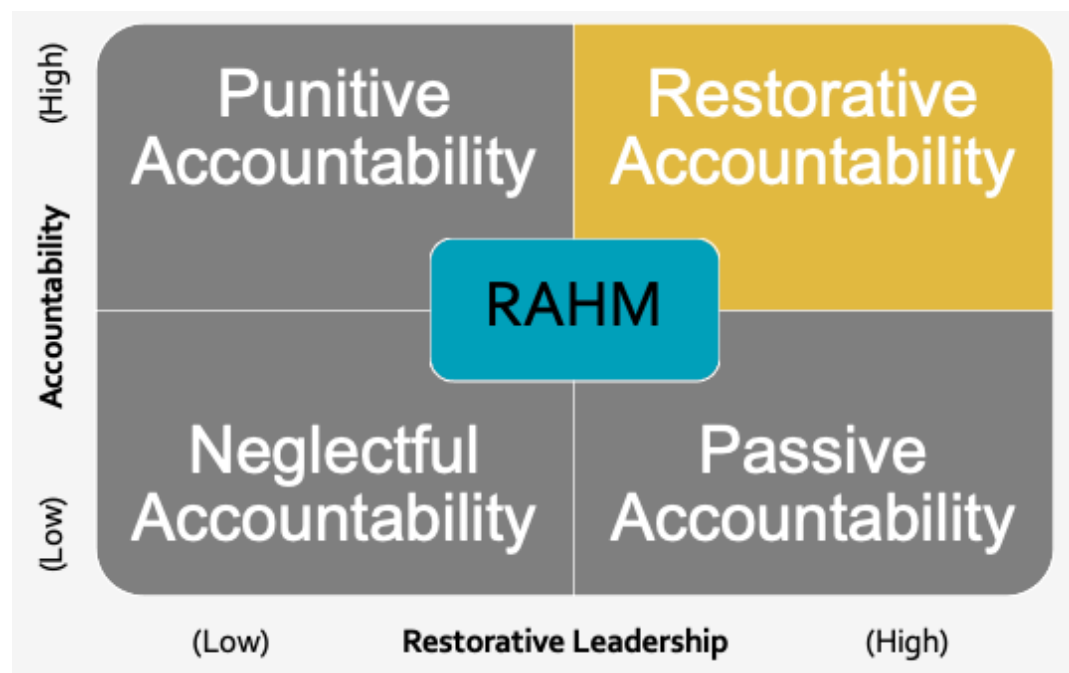
The Restorative Accountability in Healthcare Model (RAHM)

In order for healthcare leaders to adequately address the restorative imperative presented herein, a new combination of relational leadership skills and non-punitive accountability models must be adopted in healthcare settings. This point is critical because in order for restorative practices to work in hierarchical environments, where selective accountability has historically allowed mistreatment to go unaddressed, a radical change in organizational response systems for misconduct must accompany the RJ interventions. In other words, if providers who persistently cause harm are not held to the same organizational citizenship standards as everybody else in the system, the opportunity for organizational transformation will be stymied, and the deleterious outcomes presented in this study will persist.

Thus, the issue of institutional readiness to adopt a RJ culture in healthcare will require an examination of current leadership practices, passivity in responding to harm and conflict, and an overall commitment to uphold organizational values of professional conduct, civility, and respect. If this commitment is taken up as a transformational leadership initiative, from the executive level all the way down to the lowest levels of the hierarchy, then a foundational-level understanding of restorative leadership skills and non-punitive accountability models will be required of anybody who occupies a leadership position, including clinical preceptors. Therefore, prior to discussing how specific restorative practices (e.g., restorative circles and conferences) can be used in healthcare and medical learning settings to ameliorate workgroup mistreatment, the Restorative Accountability in Healthcare Model (RAHM; see Figure 7), which is a prescriptive leadership theory based on this research study's findings, will be explained in detail.

Figure 7

The Restorative Accountability in Healthcare Model (RAHM)



The RAHM was modeled after the social discipline window, which is an existing relational framework used by the International Institute for Restorative Practices (IIRP) to describe four basic approaches to maintaining social norms and behavioral boundaries (Wachtel, 2016). However, the domain of low versus high control was changed to *accountability* and the domain of low versus high support was changed to *restorative leadership*. What emerged is a quadrant model that captures four relational microsystems that exist in healthcare settings.

The **punitive accountability quadrant** (top left corner) describes a relationship of high accountability but low support, which encapsulates the coercive dynamics of blame culture, punitive leadership, and retribution. Punitive accountability means that certain providers are too fearful of reporting mistreatment (sometimes but not always due to hierarchical dynamics) because of concerns they will not be believed, and/or they will be further punished for addressing harm or conflict.

Empirical evidence: hierarchical mistreatment, blame culture, retributive culture, punitive response systems, fear culture, professional insecurity, organizational silence.

The **permissive accountability quadrant** (bottom right corner) describes a relationship of low accountability and high support, which captures the hierarchical, economic and talent factors that lead to selective accountability. Permissive accountability means that certain providers (especially those higher in the clinical or administrative hierarchy) are not held accountable for mistreating others and/or their offenses are minimized due to the positional power/influence they maintain.

Empirical evidence: minimizing or denying mistreatment; justifying misconduct due to influence, talent, or economic factors; fear of enacting relational leadership; coercive in getting needs met.

The **neglectful accountability quadrant** (bottom left corner) describes low accountability and low support, which encompasses marginalized groups and providers at the lowest levels of the clinical hierarchy. Neglectful accountability means that certain providers and disciplines lack a sense of belonging. Through systemic factors, these providers often feel marginalized and devalued due to their education-level, student status, gender, race, sexual orientation, immigration status, age, etc.

Empirical evidence: racial or gender microaggressions, student mistreatment, frank racism, violence against racialized groups, unappreciated providers, underrepresented status.

Finally, the **restorative accountability quadrant** (top right corner) describes the ideal relationship of high accountability for organizational citizenship and high support (through restorative, non-punitive leadership). Restorative accountability means that when a healthcare provider (regardless of hierarchical rank) mistreats another provider, they will be held to the same standards of organizational citizenship as anyone else in the system.

Empirical evidence: psychological debriefing sessions described on page 117, supportive leadership enacted during the emergent phases of the COVID-19 pandemic, and this study's quantitative findings.

Restorative Leadership

Supportive leadership, through acts of appreciation, respect, kindness, mutual understanding, emotional connections, psychological debriefing, and collaboration, were all found to be protective (restorative factors) in healthcare settings. Although dialogical support systems are not antithetical to healthcare's overall premise, sadly, these practices are not routinely employed, especially by healthcare leaders. Thus, the RAHM model classifies

restorative leadership as behaviors that build and strengthen relationships and respond to harm and conflict in a non-punitive way; the extent to which a leader engages in:

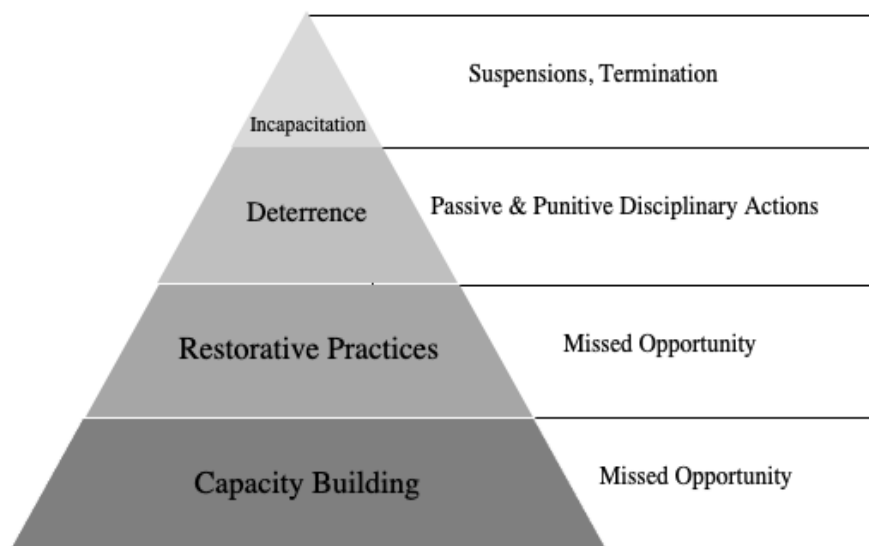
- Active listening
- Non-violent, respectful dialogue
- Storytelling
- Collaborative problem-solving
- Equitable dialogue (in dyads and teams)
- Acts of appreciation (dialogical or material)
- Emotional support (through psychological debriefing)
- Encouragement
- Creating psychologically safe work/learning environments
- Conflict management

Accountability for Misconduct (vertical axis)

Given the paradoxical leap from neglectful or passive forms of accountability for misconduct straight to punitive responses (deterrence and incapacitation), which are described in RAHM, this section will discuss opportunities for incorporating responsive regulation strategies in healthcare contexts. Revisiting Braithwaite's Regulatory Pyramid (see Figure 8), which is the conceptual framework underpinning this study, it is clear that current healthcare response systems are missing out on the benefits of the first two-tiers of the pyramid. Tier I (capacity building) can prevent harm and conflict through building and strengthening relationships and appealing to the needs of learning citizens, and Tier II (restorative practices) offer less coercive forms of justice when harm, conflict and separation has already occurred by appealing to the relational needs of virtuous citizens.

Figure 8

Braithwaite's Regulatory Pyramid Matched to Current Response Systems



It is important to note that restorative approaches to harm, Tiers 1-2 above, use a combination of the restorative leadership skills (described on page 142) and various restorative practices, which are typically led by a facilitator trained in RJ. For example, community building circles prevent harm by building and strengthening relationships, restorative conferences and climate circles respond to harm and conflict, and circles of support and accountability (COSAs) ameliorate difficult reintegration processes for providers who have left the community (through suspension or leave of absence). Thus, this paper will no longer focus on punitive approaches to harm (Tiers 3-4 above), since these practices, deterrence and incapacitation, are already used in healthcare through various human resource procedures. Conceptually then, based on this study's findings, the traditional response systems should remain in place but be used as a last resort, after a restorative approach has been tried first.

With the punitive approaches removed, what emerges are several opportunities to use restorative practices in healthcare contexts, beginning with a central tenet that is salient in both

RJ and healthcare fields, the idea of primary prevention. In 2018, David Karp, PhD and David Acosta, MD proposed a three-tiered RJ continuum (see Figure 1) for application in academic medicine settings. This study expands those recommendations to all healthcare settings, the biological sciences, academic nursing, and all the other allied health education fields, because these disciplines and learning environments are also wrought with the dysfunctional hierarchical dynamics presented in this study.

Matching Unmet Needs HCPs Reported with RJ Practices

Now that the leadership imperative has been addressed, and a new accountability paradigm has been proposed for healthcare leaders, RAHM, the following section will match the needs HCPs expressed with the corresponding restorative practices (from the RJ continuum in Figure 1), organized by tier. Additionally, the quantitative and qualitative findings of the two RJ interventions will be interleaved to substantiate recommendations. Finally, examples of how these practices can be implemented in healthcare (both virtually and in-person) will be discussed.

Tier 1: Community Building Circles

Designing a healthy work environment in healthcare will require both a cultural transformation, which can be achieved by using RAHM, as well as a set of relational practices that allow HCPs to connect with one another at deep, emotional levels. Community building circles, which are modeled after Indigenous peacemaking circles, build and strengthen relationships through creating opportunities for respectful, non-violent, and equitable dialogue. The equity component, which is achieved through using a talking piece, not only flattens the clinical and administrative hierarchies, but it also elevates marginalized voices. Through seating participants in a circle, with a centerpiece in the middle, both verbal and non-verbal cues (body

language) responses can also be more aptly perceived. Thus, the circle experience lends itself to more authentic, caring, humane, and responsive relational engagement.

Circles are powerful teambuilding strategies, too, because participation is voluntary and everyone agrees to be bound by a set of community agreements, the value-based norms that create the psychological safety needed for both vulnerability, truth-telling and healing. Values that are salient across healthcare contexts include but are not limited to: respect, honesty, compassion, dignity, empathy, integrity, equality, etc. Through skilled facilitation, ideally by a certified RJ practitioner, the circle participants eventually take collective ownership of the process through having a shared stake in upholding the value-based agreements that underpin the community's needs.

Harm Prevention

From a harm prevention standpoint, community building circles can be used to reinforce the values that already underpin healthcare, academic medicine, and academic nursing settings. Thus, circles are perfectly suited for orienting/onboarding new students and HCPs through socializing them to the values and behaviors that are traditionally bestowed upon the recipients of healthcare, the patients. According to this study's findings, 97% of student nurses believe circles helped them (1) learn multiple perspectives, (2) increase empathy, (3) reduce judgment, and (4) reduce blame. The circle experience also positively influenced the quality of relationships, with 97% of student nurses believing the relationships between the circle participants will become stronger.

In the academic medicine cohort, 91% of medical students who experienced circles would be (1) more willing to get to know their colleagues better, and (2) work toward a more

collegial work/learning environment. In fact, a medical student who participated in a community building circle, anonymously reported:

Circles should be offered as a class experience more often than just orientation. Even if its 2-3 times a year and making it integrated with course curriculum. I miss the circles from orientation, and it would be great to have "check in" reflection circles midway through the year and at the end.

Another circle participant, Lauren, a nursing student, stated of the process, "I would say it was a powerful experience, I actually teared up for some of it because I feel like people were being genuine and authentic. I was more connected to my classmates, but also more connected to myself." Thus, by proactively using community building circles to build and strengthen relationships, healthcare leaders can largely prevent mistreatment from happening in the first place.

Implementation Opportunities: New student orientation, new employee orientation, residency placements, committee work, staff meetings, leadership retreats, externship placements.

Improving the Climate

HCPs, medical students and students nurses reported a need for physical and psychological safety in both the learning environment and when collaborating in hierarchically diverse clinical teams. Given how dysfunctional hierarchies hinder communication, stymie learning, and negatively affect patient care and safety, RJ can be used as a strategy to improve the climate, rebuild trust, and improve teamwork. In fact, 97% of student nurses agree the circle experience created an environment for dialogue where everyone's perspective mattered, and

100% believe circles promote psychological safety while discussing difficult issues (e.g., mistreatment, racism in medicine, implicit bias).

In the cohort of medical students who experienced circles, the findings were also very encouraging. 99% of student doctors believing the circle experience created an environment for dialogue where everyone's perspective mattered, and 85% believing circles promote psychological safety while discussing difficult issues. Both groups unanimously agree (97%, respectively) that based on their experience with circles, RJ helps improve the climate in healthcare/nursing education settings. Thus, climate circles can be used as a responsive strategy to address campus and clinical climate concerns in an inclusive, collaborative and psychologically safe manner.

Teamwork

Using RJ to improve the quality of teamwork is especially important because dysfunctional hierarchies can endanger patient safety, undermine physician empathy, hamper learning, lower training satisfaction, and amplify stress, fatigue, and burnout (Salehi et al., 2020). However, by building and strengthening relationships through using circles, the dysfunctional cultural dynamics that lead to harm (blame culture, competitiveness, organizational silence) can be healed. Among student nurses who experienced RJ, 97% believe the circles helped them increase empathy, decrease judgment, and decrease blame. Among medical students who participated in circles, the same statistics reduced slightly to 89%. Thus, these quantitative findings demonstrate RJ's potential to transform relationships and foster opportunities for greater collaboration, innovation, and creativity, through engendering a culture of mutual appreciation and respect.

Burnout Prevention and Management

For HCPs who are experiencing the withering effects of emotional stress, intense workloads, vicarious trauma, and unhealthy work environments, restorative circles can be used as a burnout prevention strategy. By mirroring the psychological debriefing used by the PICU team on page 117, community building circles can be used as a powerful way to build individual and team resilience. Through creating humanizing experiences that allow HCPs to discuss the emotional impact the climate has had on them individually, opportunities for communal understanding and healing can emerge. Carol, a nursing manager who facilitated a community building circle with a group of RNs in a hospital setting, stated:

After we shared some fun things and laughed with each other, I opened it up to talking about things that we've observed or things that we both heard being said that maybe isn't sitting well with us. If there's something we can talk about, this is a safe space. You can talk about anything. And the only way for us to fix it is if we know about it.

Michael, a student nurse who participated in a community building circle, found the experience to be a powerful learning and healing experience, stating:

I definitely thought it was enlightening. I just feel like a lot came off our shoulders. We all came from different backgrounds, so it was really nice to just have a moment to just talk about our feelings and how we felt about these harmful situations and kind of learn from one another and heal together.

An anonymous medical student, who participated in community building circles, stated about circles and trust-building, “The sharing circles were profound and powerful. I used to do them weekly as a residence advisor with my team and they were an excellent way to build trust over sessions.”

Implementation Opportunities: optimizing teamwork, addressing campus climate concerns, debriefing painful or traumatic clinical experiences, addressing climate concerns in clinical units, addressing interdepartmental conflict, healing from morally distressing clinical scenarios.

Fostering a Sense of Belonging

In a special collaboration between the AAMC and the Center for RJ at the University of San Diego, a series of climate circles were used to convene the Council of Deans (COD) and the National Medical Student Leaders, who represent the academic medicine faculty and student body, respectively. The climate circles (see Appendix I), which were facilitated virtually via the Zoom platform, were designed to address the DEI concerns medical students were experiencing at medical colleges throughout the United States. Of central importance to the success of this particular intervention was flattening the academic medicine hierarchy so that the students and the deans could openly and honestly discuss DEI issues without becoming defensive or accusatory.

Through creating opportunities for authentic dialogue, storytelling, and collaboration, the following DEI themes emerged in the circles:

1. Relational conflict
2. Fostering a sense of belonging
3. Student safety and wellness
4. Recruitment and retention of BIPOC faculty and students
5. Bias in the learning environment

Afterwards, the circle participants collaborated on action plans that were aimed at addressing the DEI issues. The following opportunities for collaboration were identified:

1. Student support systems
2. Faculty development
3. Curriculum/Policy reform
4. Leadership/Change Management

Though quantitative data was not collected for this particular intervention, its success was measured by the ability to integrate faculty and students who were at very disparate positions of power within the academic medicine hierarchy and have them collaborate on issues of shared concern.

Among the study participants, 92% of student nurses and 77% of medical students, respectively, agreed that circles are a good venue for discussing difficult issues across multiple positional levels (e.g., faculty, staff, student), which signals a need to continue using restorative approaches to bridge hierarchical divides in academic medicine. However, both samples agreed (94% of student nurses and 89% of medical students, respectively) that based on their experience with circles, RJ helps create more diverse, equitable, and inclusive (DEI) work/learning environments.

In healthcare, similar approaches can be used to address the identity-based harms, racial or gender bias, microaggressions, or insensitivity to social issues that afflict marginalized communities, which were discussed beginning on page 68. Borrowing from Behel & Lawson's (2018) use of racial healing circles in healthcare settings, community-building circles can be used to foster mutual understanding by amplifying the voices of marginalized or underrepresented providers (e.g., by race, gender, sexual orientation, age, immigration status, student status, gender identity, etc.). Additionally, using circles to create opportunities for

intercultural dialogue can create opportunities for bridging socioeconomic and hierarchical divides.

Implementation Opportunities: racial healing circles, DEI training, responding to complaints of implicit bias, reforming marginalizing policies, curricular reform, reinforcing teaching on implicit bias and social determinants of health.

Systems Learning / Organizational Redesign

In the same way climate circles were used to create action plans for DEI issues in the AAMC intervention, restorative action plans can be used to make process changes in healthcare settings. The sequencing of circles allows for connection, storytelling, and sharing of concerns prior to making any decisions. Thus, by engaging stakeholders in listening sessions to unpack the impact of a shared concern or dysfunctional process, RJ can help healthcare leaders make decisions in a more democratic, equitable, and collaborative way. Again, an exceptional example of how this process was deployed in a healthcare context is Wailling et al.'s (2019) response to surgical mesh harm, which was discussed on page 30. Through sequencing the RJ intervention as follows: (1) listening and understanding, (2) planning and acting, and (3) reporting and evaluating, the intervention strategically engaged and empowered all stakeholders.

Process issues, like the ones identified in this study (e.g., role confusion, unclear policies and procedures, scope of practice concerns), can be addressed communally in a circle to help foster clarity, achieve consensus on what constitutes a “correct,” standardized process, and help redesign policies and procedures based on those findings. Carol, a nursing manager who used circles to address role confusion with her charge nurses, stated of the findings:

They started to open up about certain issues (without naming names), just [role confusion in the unit], and we were able to come up with some really good constructive ways to

deal with it, such as writing out expectations for the role, hour to hour. That was such a simple thing to fix, and what it boiled down to is not everybody was doing things the same way, so why can't we standardize?

Implementation Opportunities: interdisciplinary committee work, policy redesign, employee training, plan do study act (PDSA) feedback, continuous quality improvement (CQI) efforts.

Tier 2: Restorative Conferences (*Active Accountability for Harm & Conflict*)

Creating the conditions for “active accountability,” where HCPs who have harmed their colleagues are willing to take an active role in understanding the impact their behavior had on others and seek to repair the harm, rebuilding trust, and restore the fractured relationships, will require a combination of restorative leadership and skilled RJ facilitation. Though restorative conferences were not the focus of this research study, it is important to acknowledge they can play a powerful role in meaningfully redressing harm and conflict in a non-punitive, highly contextual, and typically, very sincere manner.

Rather than focusing on the policy that was violated or rule that was broken, which not only centers the offender, but typically encourages them to minimize or deny the harm/offense, restorative conferences seek to:

1. Understanding the impact of harm (on the harmed party and the community),
2. Identify the needs that emerged for the harmed party, which can be emotional/spiritual, material/physical, relational/communal, inflamed historical/structural (Karp, 2018).
3. Identify who has an obligation for repairing the harm (putting things right), which can be an individual, a healthcare team, multiple parties, administration; and can

be nested in deep seated cultural issues (blame culture, mistreatment, dysfunctional hierarchies) or inflame underlying structural/historical issues (e.g., racism, sexism),

4. To the best of their ability, repair the harm, rebuild trust, and seek to prevent harm from happening again.

Thus, the type of *justice* that emerges from restorative conferences is highly responsive, individualized and co-created by the harmed party (based on their needs), the person(s) responsible for the harm (based on their willingness to accept responsibility and repair the harm to the best of their ability), support persons, and key community stakeholders (who are invested in harm prevention and systems learning). This paradigm shift in accountability for harm and conflict will require a deep level of organizational commitment and institutional readiness. Given the leniency healthcare leaders have given certain providers, RAHM can be helpful in diagnosing permissive accountability and managing it through using restorative leadership and the restorative conference practices proposed herein.

Sharon, an HR manager who responded to a physician misconduct issue by using a restorative conference instead of a punitive approach, stated of her experience:

The physician became incredibly reflective and introspective. When she graciously agreed to meet with him, he probably put together the most authentic and genuine apology I've ever seen anyone do, and including tearing up and saying, "I'm begging for your forgiveness." It was an absolutely magnificent moment, and for me, a real testament to the fact that I think both their lives are forever changed by this experience.

Implementation Opportunities: Responding to individual incidents of workgroup mistreatment or hierarchical misconduct, including but not limited to: verbal abuse, bullying,

physical violence, public humiliation/shaming, harassment (identity-based, racial, sexual, etc.); bias incidents in healthcare and learning environments; professional misconduct cases, and student misconduct cases.

Tier 3: Restorative Reintegration (COSAs)

When healthcare or academic leaders have no other choice but to remove a provider from the work or learning environment, through suspension, the restorative continuum includes circles of support and accountability (COSAs), which can be used to strategically reintegrate a community member. Similarly, for individuals who have voluntarily left the work/learning environment, through leave of absence (personal or medical), COSAs can be used to design an individualized reintegration plan by building positive social ties (Acosta & Karp, 2018). In both cases, COSAs can be used to help welcome a provider back to the community and address the following:

1. Identify peers and support persons within the organization who can offer encouragement and support,
2. Address the community fallout, if any, of the provider's absence,
3. Revisit any time-sensitive accountability agreements (restorative action plans) the provider may have agreed to complete prior to returning to the community,
4. If they participated in a restorative conference, or agreed to restorative action plans, identify who will insure they complete the respective tasks,
5. Identify structural supports systems available to the provider through the organization and/or the community.

Implementation Opportunities: return from suspension, return from leave of absence (personal leave or medical leave), welcoming a provider or team to a new medical unit.

Conclusions

America's healthcare workforce is experiencing unprecedented rates of provider burnout and attrition, which has been exacerbated by the COVID-19 pandemic. Thus, a mass exodus of HCPs is predicted to continue, due largely to relational and environmental factors in the workplace (anxiety/depression, burnout, stress, and workloads). This study has revealed the deleterious impact workgroup mistreatment has on HCPs' mental health, which leads to a pernicious cycle of burnout, job dissatisfaction, and turnover. Beyond the intrapersonal impact, the relational dysfunction that ensues negatively affects the quality of teamwork which compromises the quality of patient care and safety. Now more than ever healthcare leaders must lean into relational, supportive, and restorative approaches to workgroup harm in order meet the societal need for medical care in the future.

Through exploring how healthcare systems are currently responding to workgroup mistreatment, it has become clear that healthcare leaders enact selective accountability when addressing workgroup mistreatment. Furthermore, healthcare leaders have expressed fears of holding certain providers accountable for mistreatment and a level of discomfort addressing conflict through enacting relational leadership. Thus, providers with positional (hierarchical), talent, and economic influence, are often not held accountable for mistreating their colleagues (those with less hierarchical power or influence), which includes medical and nursing students. Therefore, the restorative accountability in healthcare model (RAHM), a leadership paradigm, is proposed to help healthcare leaders diagnose and manage selective accountability and to implement restorative leadership strategies.

Another missed leadership opportunity is using RJs values-based, ethical framework to prevent mistreatment, redress climate concerns, and help HCPs heal themselves. Through

implementing and evaluating two RJ interventions in academic medicine and academic nursing settings, respectively, this study revealed early-adoption success of using an RJ approach to address climate concerns in healthcare. Restorative circles were found to be an extremely effective way of building and strengthen relationships, reinforcing DEI efforts, and creating a level of psychological safety needed to respond to climate concerns in a pro-social and non-punitive way. Cumulatively, this resulted in a positive improvement in relationship intentions, meaning participants would be more willing to work toward more collegial work/learning environments in the future. These findings have significant implications for improving (a) healthcare provider wellbeing, (b) teamwork, (c) patient care outcomes, (d) job satisfaction, and (e) work intentions in healthcare settings.

Finally, for healthcare systems and medical learning institutions interested in deploying an RJ approach to incivility and misconduct, a critical level of introspection will be required of healthcare administrators and leaders. If an institutional, transformational approach (aimed at creating a restorative just culture) accompanies the transactional approaches (restorative practices), then the RJ interventions will have a much more profound effect. Therefore, developing institutional readiness to deploy RJ and committing to improving the structural and cultural concerns that will inevitably emerge from restorative processes, will be of paramount importance. Through a combination of restorative leadership, fair accountability systems, and systems learning, healing the climate in healthcare is within reach.

Study Limitations

Although a high degree of scientific rigor was used in both the qualitative and quantitative stages of this study, nonetheless, this study has several limitations. First and foremost, although the study identified unjust equity harms and malpractice harms in healthcare,

the study was limited to mistreatment harms that occur in healthcare workgroups, specifically those working in acute care (hospital) environments. Thus, this study and its findings are delimited to the dysfunctional leadership and relational dynamics that occur between HCPs (workgroups) and not between HCPs and patients. Additionally, this study did not explore the benefits of using an RJ approach to address medical errors, malpractice harms, unjust health research, or to address unjust equity harms that occur at societal levels.

Furthermore, the findings cannot be generalized to all healthcare settings (e.g., outpatient clinics, doctors' offices, long-term care facilities). However, to the extent that the cultural or structural findings identified herein exist in other healthcare settings, certain aspects of this research may be transferable and beneficial. The study is also limited by volume and impact. For the qualitative stage of the study, a total of 12 HCPs who self-identified as having experienced or responded to workgroup mistreatment, were interviewed. Thus, the findings represent a thick, information-rich description of a small sample of HCPs and their experiences with workgroup harm. Thus, generalizations about their experiences cannot be made about all HCPs, all healthcare leaders, or all healthcare or medical learning environments. Additionally, though the demographic distribution of study participants was quite diverse, the qualitative and quantitative findings are biased to the experiences of registered nurses, physicians, medical students, and nursing students. Thus, HCPs of other disciplines are underrepresented.

For the quantitative stage of the study, although more than 280 medical students participated in the RJ intervention, only 53 completed the post-circle questionnaire. Thus, given the poor response rate (19%), the findings may be biased toward students who really value the RJ philosophy and may not be indicative of all the students' perspectives. However, within the student nursing cohort, where the response rate was much better (64%), the statistics were on par

with those of the medical student cohort. It is also important to note that most of the responses within the student nursing cohort were collected within 72 hours of the intervention, however, within the medical student cohort the data was collected nearly 6 months after the intervention. Interestingly, the findings indicate the intervention's impact was powerful and long-lasting. Finally, although most of the qualitative interviews were done with HCPs, the RJ interventions were biased toward student learners and not HCPs specifically. Thus, similar RJ interventions done exclusively with HCPs may reveal different findings.

Implications for Future Research

This study has revealed the impact workgroup mistreatment has on HCPs, medical students, and nursing students. Though this study demonstrated statistically significant short-term benefits of using an RJ approach to redress climate concerns in healthcare, the study did not evaluate how an RJ approach may influence healthcare climate over time. Thus, a longitudinal analysis that measures how climate variables change after deploying an RJ approach would be beneficial. Additionally, through measuring other quantitative variables (e.g., safety incidents, burnout, job satisfaction, turnover, absenteeism), the outcomes of RJ interventions can be broadened to address specific institutional goals.

Furthermore, this study focused on the foundational tiers of the RJ continuum: Tier 1 (community building circles) and Tier 2 (climate circles). Thus, future research could explore the benefits of using restorative conferences, Tier 3 (COSA's), or deploying the entire RJ continuum in healthcare and/or medical learning settings. Finally, future research could also explore the benefits of using restorative approaches to address malpractice harm, medical errors, patient-to-provider mistreatment, and to address healthcare inequities/communal harms that afflict socially disadvantaged communities.

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APPENDIX A

RESEARCH FLYER



Healthcare Providers Needed in a Research Study

Is your healthcare team experiencing climate issues such as intimidating and disruptive behaviors, bullying, hostility, or misconduct that hinders good teamwork? If so, I would like to interview you about your experiences.

You May Qualify If You

- ☐ Have at least 6 months experience working in the acute care setting
- ☐ Are a medical student who has begun clinical practicums or residencies
- ☐ Are interested in addressing workplace climate concerns and are willing to share your experiences
- ☐ Are over the age of 18

Potential Benefits

Helping researchers better understand the impact of workgroup mistreatment in healthcare/academic medicine settings, how healthcare providers and systems respond, and if restorative practices can help.

FOR MORE INFORMATION

Please contact Pedro Flores, MAS, RRT via e-mail at pflores@sandiego.edu

Participation Involves

- ☐ A 60-minute interview about the workgroup harms you've experienced, witnessed, or advised others about
- ☐ Selected participants may be invited to participate in a restorative circle, which lasts approximately 2 hours
- ☐ Completing a questionnaire

***Meetings can be in person or via Zoom*

About Restorative Justice

Restorative Circles are based on indigenous peacemaking practices. They can be used in healthcare to provide opportunities for inclusive dialogue, healing, accountability, and action plans.

APPENDIX B

CONSENT FORM



University of San Diego Institutional Review Board

Research Participant Consent Form

For the research study entitled:

**When, “First, Do No Harm” Fails:
A Restorative Justice Approach to Workgroup Harms in Healthcare**

I. Purpose of the research study

Pedro Flores, MAS, RRT is a PhD candidate in the School of Leadership and Education Sciences at the University of San Diego. You are invited to participate in a research study he is conducting. The purpose of this research study is to explore the nature of workgroup-related harms in healthcare and how restorative practices may help. Restorative practices are used to facilitate dialogues that focus on harms, needs, and solutions.

II. What you will be asked to do

If you decide to be interviewed for this study, you will be asked to participate in a confidential 60–90-minute interview about being a healthcare provider or student who has experienced workgroup-related harms. You will be audiotaped during the interview. If you decide to participate in the survey part of the study, you will be asked to complete a questionnaire about your experiences participating in a community building circle, which is a Tier 1 restorative justice intervention. The survey will also ask some demographic questions about you (e.g., title/position, gender, age, and ethnic background).

III. Foreseeable risks or discomforts

Sometimes when people are asked to think about their feelings, they feel sad or anxious. If you would like to talk to someone about your feelings at any time, you can call toll-free, 24 hours a day: **San Diego Mental Health Hotline at 1-800-479-3339**

IV. Benefits

While there may be no direct benefit to you from participating in this study, the indirect benefit of participating will be knowing that you helped researchers better understand what type of workgroup harms occur in healthcare/academic medicine, how healthcare providers respond, and whether restorative practices are beneficial in redressing those harms.

V. Confidentiality

Any information provided and/or identifying records will remain confidential and kept in a locked file and/or password-protected computer file in the researcher's office for a minimum of five years. All data collected from you will be coded with a number or pseudonym (fake name). Your real name will not be used. The results of this research project may be made public and information quoted in professional journals and meetings, but information from this study will only be reported as a group, and not individually.

VI. Compensation

You will receive no compensation for your participation in the study.

VII. Voluntary Nature of this Research

Participation in this study is entirely voluntary. You do not have to do this, and you can refuse to answer any question or quit at any time. Deciding not to participate or not answering any of the questions will have no effect on any benefits you're entitled to, like your health care, or your employment or grades. **You can withdraw from this study at any time without penalty.**

VIII. Contact Information

If you have any questions about this research, you may contact either:

- 1) Pedro Flores, MAS, RRT
Email: pflores@sandiego.edu
Phone: 951-704-2907
- 2) David Karp, PhD
Email: dkarp@sandiego.edu
Phone: 619-260-4760

I have read and understand this form, and consent to the research it describes to me. I have received a copy of this consent form for my records.

Signature of Participant

Date

Name of Participant (printed)

Signature of Investigator

Date

APPENDIX C

INTERVIEW GUIDE

Interview Guide

Grand Tour Questions:

1. Let's talk about your typical workday. How would you describe the essence of what you do (not your title)?
2. Have you ever experienced a situation where someone did something at work that undermined a sense of good teamwork?

Follow-Up Questions:

1. Can you tell me about someone you've worked with who's been a victim of workplace harm, harassment or bullying?
2. What kinds of harms have you experienced as a health care provider? Can you tell me about a time you were harmed, harassed or bullied by someone you worked with?
 - a. Or, can you tell me about a time you advised someone who was harmed, harassed or bullied?
3. How are you dealing (have you dealt) with the harms you've experienced? How has this impacted you?

a. Internal Probes:

- i. Negative emotions
- ii. Negative behaviors

b. External Probes:

- i. Have you ever requested support/treatment from within the organization?
- ii. Have you received support/treatment from outside of the organization?

- iii. What systems are in place to help support people who have experienced coworker-related harms?
 1. Did you use them, and how did it go?
 2. If you opted not to use them, why not?
4. In what ways, if any, have you deliberately, complicitly, or perhaps unknowingly participated in intimidating/disruptive behaviors at work? Either as an individual or in a group?
5. Is there something about working in the hospital setting that makes misconduct more prevalent?
6. Are there departments or teams within the hospital where misconduct is more likely to occur and why?
7. Without mentioning names or titles, can you think of an individual or team who is known to be intimidating, disruptive or difficult to work with?
 - a. What is it about working with them that makes your job more difficult?
8. Are there any individuals you work whose personality or disposition makes it difficult for you to address your patients' needs with? What is it about them that make you feel this way?
9. In what ways does hospital administration contribute to these harms happening?
10. In what ways have you seen hospital administration or leadership deal with these harms?
11. Do you have any more thoughts or ideas about why healthcare providers experience workgroup harms, harassment, intimidation or bullying?

APPENDIX D

RJ INTERVENTION FLYER



Healthcare Team Needed for a Restorative Justice Research Study

Is your healthcare team experiencing climate issues such as intimidating and disruptive behaviors, bullying /hostility, or anything else that hinders good teamwork? If so, you may be eligible for a free restorative justice pilot.

You May Qualify If You

- ☐ Are a multidisciplinary healthcare team of 6-12 clinician, medical students or nursing students
- ☐ Work in an acute care setting
- ☐ Are interested in addressing workplace climate concerns and are willing to share your experiences
- ☐ Are over the age of 18

Potential Benefits

Participating in this study may result in deeper connections between colleagues, improved workplace climate, and finding solutions to conflict/climate issues at your institution.

Participation Involves

- ☐ Participating in a community building circle, which typically lasts 2 hours
- ☐ Completing a post-circle questionnaire
- ☐ Selected participants may be invited to participate in a follow-up interview (60 min)

*** Meetings can be in person or via Zoom*

About Restorative Justice

Climate Circles are based on indigenous practices. They can be used in healthcare to provide opportunities for inclusive dialogue, healing, accountability, and action plans.

FOR MORE INFORMATION

Please contact Pedro Flores, MAS, RRT at 951-704-2907 or via e-mail at pflores@sandiego.edu

APPENDIX E

STUDENT NURSING CIRCLE PROTOCOL

Meet the RJ Team

- Bridget welcomes back the students and hands it over to the RJ training team
- Pedro introduces Justine and the SOLES RJ training team

What to expect today

- We're going to start right away with a community building circle where you'll be sharing about your journey towards pursuing a career in nursing and discuss implicit bias in healthcare (2 circles of about 8 students will be held here, the other 4 circles will be in other classrooms)
- We'll debrief the experience back here at about 10:50 am
- We'll start to visualize how these practices can serve the nursing profession and your personal relationships.

Opening Ceremony

- Land Acknowledgment connected to Medicine Wheel teachings

Mindfulness Moment

- Guided Breathing Exercise

Opening the circle

- The **purpose** of the circle is to connect with one another through storytelling and sharing perspectives. We'll be actively listening to one another and working together to create a space that invites authenticity.
- Everything in circle is an **invitation**. We will use a talking piece which reminds us to give our full attention to the speaker. You're welcome to pass when the talking piece comes to you, and you'll get another invitation at the end of the round.
- **Community Agreements:** Let's create agreements, starting with basics:
 - Be present & curious
 - Speak & listen from the heart
 - Speak & listen with respect
 - Say just enough
 - Respect the taking piece
 - Take the learning, leave the stories (HIPPA)
 - *Are there any additional needs? Requests for modifications? Accommodations for students with disabilities?*
 - When complete, ask for consensus by raising hands

Split students into 6 circles of 8-9 students

Student Nursing Circles

- **First round (introduction and values)**
 - The facilitator will introduce themselves and the talking piece they have chosen
 - Using markers and name cards, on one side write down your name and on the other a value or strength you're leading with today.
 - **State your name (pronouns if you wish) and a strength or value you're leading with today.**
 - *The facilitator will begin by modeling the exercise.* After your introduction, place your name facing the center of the circle (our values are facing us as a reminder of the container we've created for our special space). Example: Bridget / Diversity. Pass the talking piece to your left.
- **Storytelling round:**
 - To create a powerful connection between us, we have asked you to reflect on the following prompt:
 - **"Please share something nobody would know about your journey toward becoming a nurse."** You will want to actively listen to the person's story right after your own as you will be asked to reflect back their story in the next round.
- **Reflection round:**
 - **Reflect on what it was like to hear from the colleague sitting to the left of you about their nursing journey. What resonated with you? If possible, make a personal connection.**
 - We will follow the same speaking order (first person reflects on second person's story, 2nd on 3rd, etc.)
 - *The facilitator will model this if necessary. If you have difficulty recalling something important about the story, don't worry, the group can help you. Just ask.*
- **Concern round:**
 - You've just learned about implicit bias in healthcare. It has become clear that healthcare is not perfect and that various harms befall individuals and communities. The following questions are meant to help us imagine a more "just" healthcare system and how restorative justice may help you in your role as a future nurse.
 - **Based on your learning and reflections so far, what has been stirred in you? What individual or institutional challenges of this type have you experienced or witnessed?**
- **Action planning round:**
 - **What is something I can do as a future nurse to prevent mistreatment, biased care, or racism in medicine?**
- **Closing round:**
 - **What are you taking with you from this circle today?**

APPENDIX F

MEDICAL STUDENT CIRCLE PROTOCOL

Warm Welcome**Round #1 - Introductions**

Invite everyone in your breakout room to introduce themselves - *(Note: You model first and pass to your left or right.*

- Name and Pronouns (optional) *Please model by adding sharing the pronouns you use to pave the way for those who want to share.*
- What is one brief story about your name (e.g., meaning, how you were named, a nickname, etc.)

Round #2 - Implementing the Principles of Inclusion Excellence

- What is one concrete way you can *support* Inclusion Excellence as a member of our community?
- What is one thing you need from others in the community to *experience* Inclusion Excellence?

Round #3 - Journey to Osteopathic Medicine

- What personal object represents your journey to osteopathic medicine?

Invite participants to listen deeply while each person shares the story behind their object. What connections do they have to the story or object? They will have the opportunity to acknowledge these connections in the next round.

Round #4 - Honoring Connections

- *Identify a connection you have to the story or object of the person seated next to you in circle.*
- *(insert name), I heard you say (reflect brief summary) about your journey/object. A connection I feel to your story/object is...*

Round #5 - Closing Round

- What is becoming clearer to me is...
- I just want to say... *(Feel free to add anything you want to say to feel complete with our circle.)*

Note: If there is time left before returning to the main room, please invite people to ask questions and/or share what their experience was in circle.

APPENDIX G

ESSENTIAL ELEMENTS OF A CIRCLE

Essential Elements for Constructing the Circle

Kay Pranis

The Circle is a structured dialog process that nurtures connections and empathy, while honoring the uniqueness of each participant. The Circle can hold pain, joy, despair, hope, anger, love, fear, and paradox. In the Circle, each person has the opportunity to speak his/her truth but cannot assume the truth for anyone else. The Circle welcomes difficult emotions and difficult realities, while maintaining a sense of positive possibilities. The Circle is deeply rooted in an understanding of profound interconnectedness as the nature of the universe.

The Circle Keeper uses the following elements to design the Circle and to create the space for all participants to speak their truth respectfully to one another and to seek resolution of their conflict or a greater understanding of one another's perspective.

- **Seating all participants in a circle (preferably without any tables)**
- **Opening ceremony**
- **Centerpiece**
- **Values/guidelines**
- **Talking piece**
- **Guiding questions**
- **Closing ceremony**

Seating all participants in a circle – Geometry matters! It is very important to seat everyone in a circle. This seating arrangement allows everyone to see everyone else and to be accountable to one another face to face. It also creates a sense of focus on a common concern without creating a sense of 'sides'. Sitting in a circle emphasizes equality and connectedness. Removing tables is sometimes uncomfortable for people but is important in creating a space apart from our usual way of discussing difficult issues. It increases accountability because all body language is obvious to everyone.

Opening ceremony – Circles use openings and closings to mark the Circle as a sacred space in which participants are present with themselves and one another in a way that is different from an ordinary meeting or group. The clear marking of the beginning and end of the Circle is very important, because the Circle invites participants to drop the ordinary masks and protections they may wear that create distance from their core self and the core self of others. Openings help participants to center themselves, bring themselves into full presence in the space, recognize interconnectedness, release unrelated distractions, and be mindful of the values of the core self.

Centerpiece – Circles use a centerpiece to create a focal point that supports speaking from the heart and listening from the heart. The centerpiece usually sits on the floor in the center of the open space inside the circle of chairs. Typically there is a cloth or mat as the base. The centerpiece may include items representing the values of the core self, the foundational principles of the process, and/or a shared vision of the group. Centerpieces often emphasize inclusion by incorporating symbols of individual Circle members as well as cultures represented in the Circle.

Guidelines – Participants in a Circle play a major role in designing their own space by creating the guidelines for their discussion. The guidelines articulate the agreements among participants about how they will conduct themselves in the Circle dialog. The guidelines are intended to describe the behaviors that the participants feel will make the space safe for them to speak their truth. Guidelines are not rigid constraints but supportive reminders of the behavioral expectations of everyone in the Circle. They are not

imposed on the participants but rather are adopted by the consensus of the Circle.

Talking piece – Circles use a talking piece to regulate the dialog of the participants. The talking piece is passed from person to person around the rim of the Circle. Only the person holding the talking piece may speak. It allows the holder to speak without interruption and allows the listeners to focus on listening and not be distracted by thinking about a response to the speaker. The use of the talking piece allows for full expression of emotions, thoughtful reflection, and an unhurried pace. Participants are free to speak or pass when the talking piece comes to them. The talking piece is a powerful equalizer. It allows every participant an equal opportunity to speak and carries an implicit assumption that every participant has something important to offer the group. As it passes physically from hand to hand, the talking piece weaves a connecting thread among the members of the Circle. The talking piece reduces the control of the keeper and consequently shares control of the process with all participants. Where possible, the talking piece represents something important to the group. The more meaning the talking piece has (consistent with the values of Circle), the more powerful it is for engendering respect for the process and aligning participants with their core selves.

Guiding questions – Circles use prompting questions or themes at the beginning of rounds to stimulate conversation about the main interest of the Circle. Every member of the Circle has an opportunity to respond to the prompting question or theme of each round. Careful design of the questions is important to facilitate a discussion that goes beyond surface responses. Questions are often designed to invite participants to share personal stories relevant to the theme raised.

Closing ceremony – Closings acknowledge the efforts of the Circle, affirm the interconnectedness of those present, convey a sense of hope for the future, and prepare participants to return to the ordinary space of their lives. Openings and closings are designed to fit the nature of the particular group and provide opportunities for cultural responsiveness.

Keeper's role – The role of the facilitator(s) or keeper(s) of the Circle is to assist the participants in creating a safe space where each can speak and listen from the heart. The keeper—and sometimes there are two—helps the Circle create the space and then monitors the quality of the space. The keeper is not an enforcer of Circle guidelines but the guardian of them. Every member of the Circle bears responsibility for the quality of the dialog. If the dialog becomes disrespectful, the keeper invites the Circle to discuss what is happening and how to move toward a more respectful interaction.

The Circle keeper is a participant and can speak in turn in the Circle. Sometimes the keeper speaks first in a round to model the kind of response being invited or to model the sharing of personal stories. At other times, the keeper speaks last in a round to reduce the risk of the keeper influencing the dialog inappropriately.

The Circle keeper attempts to hold an attitude of compassion and caring for every member of the Circle, regardless of behavior.

Circle dialog – Circles are never about persuasion. They are a process of exploring meaning from each perspective in the Circle. From that exploration we may find common ground or we may understand more clearly why another person sees something differently. The more diverse the perspectives are in a Circle, the richer the dialog and the greater the opportunity for new insights will be. The keeper does not control this process but helps the Circle work through uncomfortable moments by maintaining the use of the talking piece going in order around the Circle and by engaging the Circle in reflection on its own process when needed.

APPENDIX H

CIRCLE EVALUATION QUESTIONNAIRE

Operational Construct	Question
Ceremony's influence on authenticity (fidelity to circle process)	Q1 - The structure of the circle created a space for dialogue that helped me share more authentically.
Mindfulness	Q2 - The circle experience helped me disconnect from other distractions.
Emotional connection with peers	Q3 - The circle experience made me feel more connected to my peers/colleagues.
Emotional connection with institution	Q4 - The circle experience made me feel more connected to the institution where the circle was held.
Strengthening relationships	Q5 - As a result of the circle experience, I believe the relationships between the circle participants will become stronger.
Equitable Dialogue	Q6 - The circle experience created an environment for dialogue where everyone's perspective mattered.
Flattening Hierarchies	Q7 - Circles are a good venue for discussing difficult issues across multiple positional levels (e.g., faculty, staff, student).
Elevating Marginalized Voices	Q8 - In the circle, people who don't usually have a voice had a chance to authentically share their perspectives.
Mutual understanding of complex phenomena	Q9 - I believe circles can help me learn multiple perspectives.
Increasing empathy	Q10 - I believe circles can help me increase empathy.
Reducing judgment	Q11 - I believe circles can help me reduce judgment.
Reducing blame	Q12 - I believe circles can help me reduce blame.
Improving psychological safety	Q13 - I believe circles may promote psychological safety while discussing difficult issues.
Addressing conflict	Q14 - In the circle, we were able to discuss difficult issues (e.g., learner mistreatment, implicit bias in healthcare) openly and honestly.
Collaboration/Action Planning	Q15 - In the circle, we were able to create action plans/solutions for difficult issues (e.g., learner mistreatment, implicit bias in healthcare).
RJ Aligns with institutional values	Q16 - I believe circles are a radical departure from what we usually do and more aligned with the values that have been established at this institution.
RJ helps create a just and learning culture	Q17 - I believe circles are a radical departure from what we usually do and more aligned with the institution's goals of creating a just and learning culture.
RJ aligns with healthcare values	Q18 - I believe circles are a radical departure from what we usually do and more aligned with the values that underpin healthcare.

Deepen relationships	Q19 - Based on my experience in the circle, I would be more willing to get to know my colleagues better.
Improving climate (work environment)	Q20 - Based on my experience in the circle, I would be more willing to actively work toward a more collegial work/learning environment.
Use RJ to solve problems	Q21 - Based on my experience in the circle, I would be more willing to work through a difficult team issue using circles.
Use RJ as a leadership strategy	Q22 - Based on my experience in the circle, I would be more willing to use restorative circles as a leadership strategy.
Change my perspective & deepen relationships	Q23 - For this question, reflect on a person or persons in your circle you didn't know well or get along with. After the circle, rate your willingness to improve your relationship with them (transtheoretical model of change)
Build & Strengthen Relationships	Q24 - Based on my experience with circles, I believe restorative justice helps create deeper, more meaningful relationships between colleagues.
Create Diverse, Equitable, and Inclusive (DEI) work environments	Q25 - Based on my experience with circles, I believe restorative justice helps create more diverse, equitable, and inclusive (DEI) work/learning environments.
Improve the climate in healthcare/learning environments?	Q26 - Based on my experience with circles, I believe restorative justice helps improve the climate in healthcare/nursing education settings.
Transferability of RJ to healthcare and academic learning settings?	Q27 - I think the institution where the circle was held would benefit from additional restorative justice implementation.

APPENDIX I

AAMC/USD CLIMATE CIRCLE PROTOCOL



Community Building Circles: COD and National Medical Student Leaders

Community Building Circles: Council of Deans (COD) Administrative Board and National Medical Student Leaders

Sample Protocol for Community Debrief Session
December 13, 2021

Description

AAMC staff collaborated with trained facilitators from the University of San Diego Center for Restorative Justice to develop the protocol below, which was piloted in community building circles between COD Administrative Board members and national medical student leaders in August and October 2021. The objective of the circles was to convene deans and students to discuss diversity and inclusion in medical school, with a particular focus on learning more about the students' lived experiences. Each circle contained no more than eight participants and was led by a trained facilitator from the Center (Pedro Flores, MAS, RRT or Hyacinth Mason, PhD). The protocol is shared as an example of restorative justice practices applied within academic medicine, in particular to build understanding between medical students and medical school administrators.

Sample Protocol

Time	Circle Process
1 min	Welcome (AAMC staff) <ul style="list-style-type: none"> Welcome on behalf of the AAMC and introduction of community building circle facilitators
5 min	Introduction to Restorative Justice (RJ Facilitator) <ul style="list-style-type: none"> Land acknowledgement Facilitator self-introduction(s) Brief overview of restorative justice practices
2 min	Purpose (RJ Facilitator) <ul style="list-style-type: none"> We are living through unprecedented times. COVID-19 changed our lives in so many ways. However, for some, the pandemic has had a greater impact, due to disproportionate rates of infection, hospitalization, and death for Black, Latino and American Indian communities. While not new, together as a nation, we have also witnessed the horrific acts of anti-Black violence and now growing more aware of anti-Asian violence. These acts of violence have been the catalyst for change and a call to action to tackle racism. For us, this underscores the critical need to be more responsive to calls for diversity, anti-racism, equity and inclusion. This community building circle will allow us to slow down and listen deeply to understand each other's perspectives. We are developing a space in which power is shared and we have equitable space here. We want to learn how to better create medical school cultures that are diverse, inclusive, and anti-racist. One way is by strengthening our relationships and building a sense of shared purpose amongst our communities.
2 min	Mindfulness Moment: Box breathing (RJ Facilitator)



Community Building Circles: COD and National Medical Student Leaders

	<ul style="list-style-type: none"> • Invite participants to relax into their seats and close or lower eyes to gaze on something fixed and not a screen. • Guide at least 3 rounds of box breathing: <ul style="list-style-type: none"> ○ Breathe in through the nose for a count of 4 ○ Hold for a count of 4 ○ Breathe out through the mouth for a count of 4 ○ Hold for a count of four • Invite participants back with a suggestion to wiggle toes and fingers and gently return to the room. Take note of any differences you notice in the space.
2 min	<p>Agreements (RJ Facilitator)</p> <ul style="list-style-type: none"> • In the circle: <ul style="list-style-type: none"> ○ We are focused on building community and creating a sense of belonging ○ We will take turns speaking ○ It is okay to pass or to be silent ○ If someone passes, offer another opportunity later ○ Be present and curious ○ Speak and listen with respect ○ Speak and listen from the heart ○ Be patient ○ Take the learning, leave the stories • Are there any other agreements you want to include that will foster a safe and comfortable space to be open and honest? Or do you have any modifications to suggest? • Gain consensus before moving on.
15 min	<p>Introductions and Connection</p> <ul style="list-style-type: none"> • Introductions <ul style="list-style-type: none"> ○ Name, and a strength or value you're leading with today. This will establish our speaking order. • To create a powerful connection among us, we have asked you to reflect on the following prompt: "Please share something that no one would know about your journey toward pursuing a career in medicine." • RJ facilitator goes first to model what to expect from the circle.
3 min	<p>Reflection about the talking circle</p> <ul style="list-style-type: none"> • Reflect on what it was like to hear from your colleagues about their talking piece.
50 min	<p>Diversity and Inclusion in Medicine (RJ Facilitators)</p> <ul style="list-style-type: none"> • Our goal today is to gain insights into how we can contribute to more diverse, equitable, and inclusive learning and working environments. Each of you have a vested interest in creating a positive and enriching learning and working environment at your respective medical schools. Everyone here values diversity, equity, and inclusion and understands that as an academic medicine community we need to do more. • Discussion Questions: <ul style="list-style-type: none"> a) From your perspective, what does it mean to have a diverse, equitable, and inclusive medical school?



Community Building Circles: COD and National Medical Student Leaders

	<p>b) What challenges have you experienced personally or institutionally in working toward an ideal learning environment?</p> <p>c) What specific actions can you take in your role to help promote greater diversity, equity, and inclusion?</p>
10 min	<p>Closing Round (RJ Facilitators start)</p> <ul style="list-style-type: none"> • Debrief and key takeaways • RJ Facilitator asks participants "Please share one word that captures how you are feeling/hopes next steps as we close for today." • RJ Facilitator provides closing remarks that summarize the experience, relate to the original intent, identify what I learned, and honor the achievement of the group in creating and maintaining a respectful space. • RJ Facilitator thanks everyone for participating in the Circle today and committing to the learning process.

APPENDIX J
INSTITUTIONAL REVIEW BOARD APPROVAL



Mar 3, 2020 4:20 PM PST

Pedro Flores
Sch of Leadership & Ed Science

Re: Initial - IRB-2020-249 Using Restorative Justice to Redress Employee Harms in Healthcare.

Dear Dr. Pedro Flores:

University of San Diego Human Subjects Review Board has rendered the decision below for Using Restorative Justice to Redress Employee Harms in Healthcare..

Decision: Approved

Findings: None

Research Notes:

Internal Notes:

Note: We send IRB correspondence regarding student research to the faculty advisor, who bears the ultimate responsibility for the conduct of the research. We request that the faculty advisor share this correspondence with the student researcher.

The next deadline for submitting project proposals to the Provost's Office for full review is N/A. You may submit a project proposal for expedited or exempt review at any time.

Sincerely,