

How to Build **Psychological Safety** in Medical Education

Dr. Lillian Au, MD, CCFP, FCFP, MEd (HSE)

Submission ID: 257

NOVEMBER 5-8, 2025
RBC CONVENTION CENTRE WINNIPEG, MB



PRESENTER DISCLOSURE

Presenter: **Lillian Au**

Relationships with financial sponsors:

Any direct financial relationships, including receipt of honoraria:

Department of Family Medicine, University of Alberta.

Membership on advisory boards or speakers' bureaus:

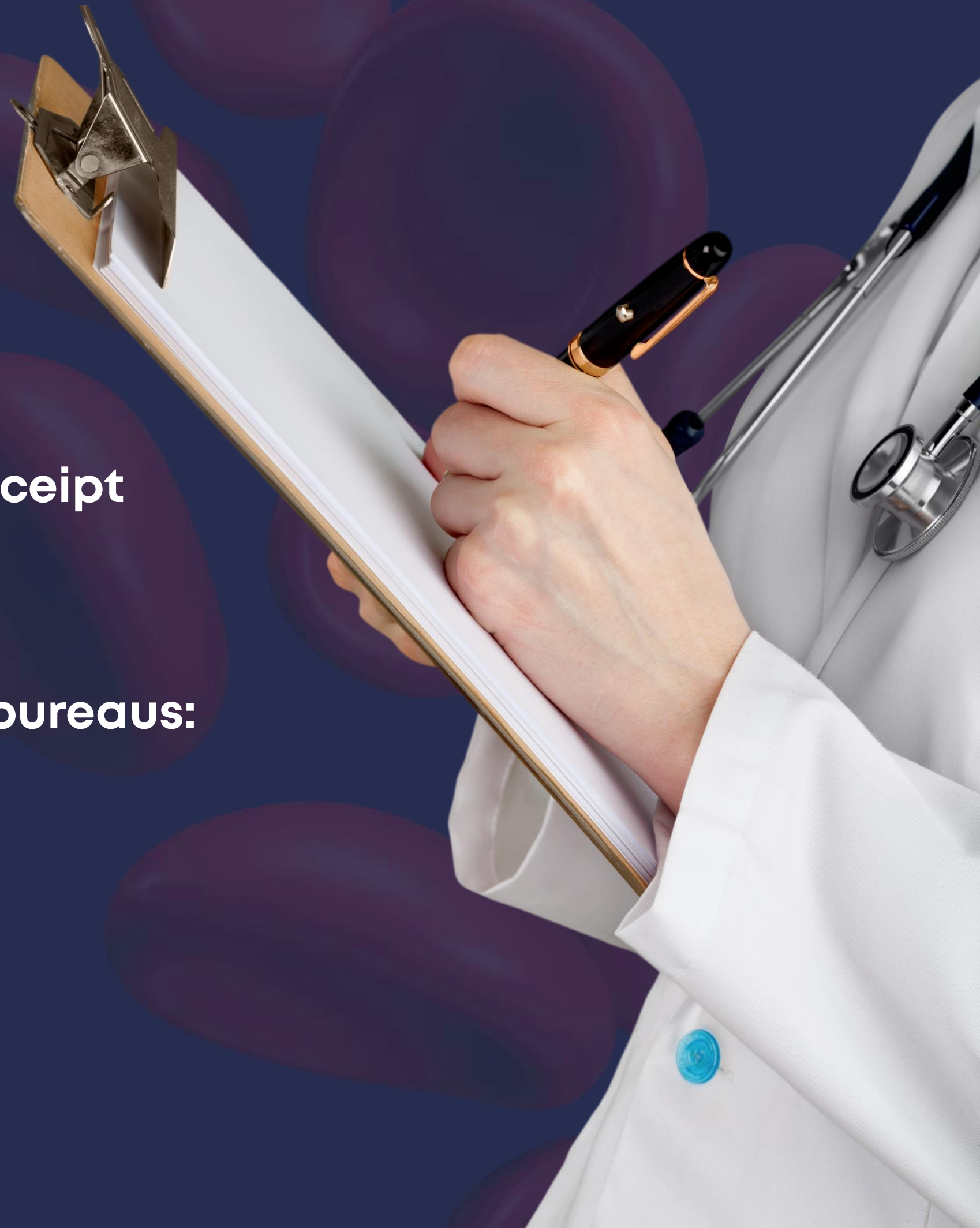
none

Patents for drugs or devices:

none

Other:

none



DISCLOSURE OF FINANCIAL SUPPORT



This program has received financial support from **Department of Family Medicine** in the form of **coverage of travel costs**



This program has received in-kind support from **Family Medicine Forum** in the form of **logistical support & tech support**



Potential for conflict(s) of interest:
none

How to Build **Psychological Safety** in Medical Education

OBJECTIVES

1

Define psychological safety and its importance in medical education.

2

Discuss the specific barriers of psychological safety embedded in the culture of medical training.

3

Apply strategies on how to improve and develop psychological safety in the clinical environment.

What IS **Psychological Safety**?

Amy Edmondson, 1999:

Defines psychological safety as a belief that no one is punished or humiliated for speaking up with ideas, questions, concerns or mistakes.



**Think about when you
were on a clinical team
as a medical student...**

**What do you notice with this
picture?**



**Think about when you
were on a clinical team
as a medical student...**

Safe learning environments?

What factors made these
environments feel safe (to
speak up)?



**Think about when you
were on a clinical team
as a medical student...**

Unsafe clinical environments?

What factors made these
environments feel unsafe
(reluctance to speak up)?



35a

For each of the following behaviours, please indicate the frequency you personally experienced that behaviour during medical school. Include in your response any behaviours performed by faculty, nurses, residents/interns, other institution employees or staff, and other students. Please do not include behaviours performed by patients and their families. During medical school, how frequently have you been.

Response options: Never; Once; Occasionally (2-4 times); Frequently (5 or more times). For the purposes of analysis, the response options listed above were coded from 1 to 4, respectively.

Note: Percentages (ratings) add to 100 across rows, not columns.

		Ratings (%)				Count	Mean	Standard Deviation
		Never	Once	Occasionally (2-4 times)	Frequently (5 or more times)			
Publicly humiliated	2024	58.7	17.2	21.3	2.8	1419	1.68	0.90
	2023	57.4	19.2	20.7	2.6	1363	1.69	0.89
	2022	54.9	18.6	23.5	3.0	1641	1.75	0.92
Threatened with physical harm	2024	96.6	2.1	1.2	0.1	1422	1.05	0.28
	2023	97.6	1.8	0.6	0.0	1362	1.03	0.20
	2022	97.6	1.5	0.7	0.2	1645	1.03	0.24
Physically harmed	2024	97.5	2.0	0.5	0.0	1419	1.03	0.20
	2023	98.3	1.5	0.1	0.0	1363	1.02	0.14
	2022	98.6	1.2	0.1	0.1	1643	1.02	0.15
Required to perform personal services	2024	88.9	5.0	5.2	0.8	1419	1.18	0.55
	2023	90.2	4.4	4.5	0.9	1364	1.16	0.53
	2022	88.3	5.3	5.9	0.5	1641	1.19	0.55

Wait.... Is there a problem?

YES!

35a

For each of the following behaviours, please indicate the frequency you personally experienced that behaviour during medical school. Include in your response any behaviours performed by faculty, nurses, residents/interns, other institution employees or staff, and other students. Please do not include behaviours performed by patients and their families. During medical school, how frequently have you been.

Response options: Never; Once; Occasionally (2-4 times); Frequently (5 or more times). For the purposes of analysis, the response options listed above were coded from 1 to 4, respectively.

Note: Percentages (ratings) add to 100 across rows, not columns.

		Ratings (%)				Count	Mean	Standard Deviation
		Never	Once	Occasionally (2-4 times)	Frequently (5 or more times)			
Publicly humiliated	2024	58.7	17.2	21.3	2.8	1419	1.68	0.90
	2023	57.4	19.2	20.7	2.6	1363	1.69	0.89
	2022	54.9	18.6	23.5	3.0	1641	1.75	0.92
Threatened with physical harm	2024	96.6	2.1	1.2	0.1	1422	1.05	0.28
	2023	97.6	1.8	0.6	0.0	1362	1.03	0.20
	2022	97.6	1.5	0.7	0.2	1645	1.03	0.24
Physically harmed	2024	97.5	2.0	0.5	0.0	1419	1.03	0.20
	2023	98.3	1.5	0.1	0.0	1363	1.02	0.14
	2022	98.6	1.2	0.1	0.1	1643	1.02	0.15
Required to perform personal services	2024	88.9	5.0	5.2	0.8	1419	1.18	0.55
	2023	90.2	4.4	4.5	0.9	1364	1.16	0.53
	2022	88.3	5.3	5.9	0.5	1641	1.19	0.55

So...what is going on?

Why is shaming STILL

a problem in medical

education?

Is it just about pimping?

remain in widespread use.¹ While “pimping” has no single, universal definition, it is often described as the practice of asking trainees questions in a manner that establishes and reinforces a dominant intellectual hierarchy and stresses the trainee.²⁻⁴

The Art of Pimping

IT'S HARD work becoming a revered attending physician in a university hospital. The task daunts the newly appointed junior attending as he strides down the corridor of his first ward with his first team. Oh, he's made some changes in anticipation of his new position. He's wearing a long coat now, an all-cotton coat with razor-sharp creases and knit buttons. The stained, shrunken polyester white pants and tennis shoes have given way to gray, light wool slacks with a cuff and polished loafers. Framed certificates bear testimony to his intelligence and determination. He should be ready to take the helm of his ward team, but he's not. Something's missing, something important, something closer to art than to science. When physicians talk about the “art of medicine” they usually mean healing, or coping with uncertainty, or calculating their federal income taxes. But there's one art this new attending needs to learn before all others: the art of pimping.

Pimping occurs whenever an attending poses a series of very difficult questions to an intern or student. The earliest reference to pimping is attributed to Harvey in London in 1628. He laments his students' lack of enthusiasm for learning the circulation of the blood: “They know nothing of Natural Philosophy, these pin-heads. Drunkards, sloths, their bellies filled with Mead and Ale. O that I might see them pimped!”

In 1889, Koch recorded a series of “Pümpfrage” or “pimp questions” he would later use on his rounds in Heidelberg. Unpublished notes made by Abraham Flexner on his visit to Johns Hopkins in 1916 yield the first American reference: “Rounded with Osler today. Riddles house officers with questions. Like a Gatling gun. Welch says students call it ‘pimping.’ Delightful.”

On the surface, the aim of pimping appears to be Socratic instruction. The deeper motivation, however, is political. Proper pimping inculcates the intern with a profound and abiding respect for his attending physician while ridding the intern of needless self-esteem. Furthermore, after being pimped, he is drained of the desire to ask new questions—questions that his attending may be unable to answer. In the heat of the pimp, the young intern is hammered and wrought

pimping as a medical art has received little attention from the educational establishment. A recent survey reveals that fewer than 1 in 20 attending physicians have had any formal training in pimping. In most American medical schools, pimping is covered haphazardly during the third-year medical clerkship or is relegated to a fourth-year elective. In a 1985 poll, over 95% of program directors admitted that the pimping skills of their trainees were “seriously inadequate.” It comes as no surprise, then, that the newly appointed attending must teach himself how to pimp. It is to this most junior of attendings, therefore, that I offer the following brief guide to the art of pimping.

Pimp questions should come in rapid succession and should be essentially unanswerable. They may be grouped into five categories:

1. Arcane points of history. These facts are not taught in medical school and are irrelevant to patient care—perfect for pimping. For example, who performed the first lumbar puncture? Or, how was syphilis named?

2. Teleology and metaphysics. These questions lie outside the realm of conventional scientific inquiry and have traditionally been addressed only by medieval philosophers and the editors of the *National Enquirer*. For instance, why are some organs paired?

3. Exceedingly broad questions. For example, what role do prostaglandins play in homeostasis? Or, what is the differential diagnosis of a fever of unknown origin? Even if the intern begins making good points, after 4 or 5 minutes he can be cut off and criticized for missing points he was about to mention. These questions are ideally posed in the final minutes of rounds while the team is charging down a noisy stairwell.

4. Eponyms. These questions are favored by many old-timers who have assiduously avoided learning any new developments in medicine since the germ theory. For instance, where does one find the semilunar space of Traube? Or, whose name is given to the dancing uvula of aortic regurgitation?

5. Technical points of laboratory research. Even when general medical practice has become a dim and distant memory,

Received: 7 January 2022 | Accepted: 21 April 2022
DOI: 10.1002/jhm.12846

CHOOSING WISELY®: THINGS WE DO FOR NO REASON™

Journal of
Hospital Medicine **shm**
Society of Hospital Medicine

Things We Do for No Reason™: Toxic quizzing in medical education

Benjamin Kinnear MD, MEd^{1,2} | Bailey DeCoursey¹ | Teresa Caya MD³ |
Javier Baez MD² | Eric J. Warm MD⁴

¹Department of Pediatrics, Cincinnati Children's Hospital Medical Center, University of Cincinnati College of Medicine, Cincinnati, Ohio, USA

²Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio, USA

³Resident (PGY-4), Internal Medicine and Pediatrics, Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio, USA

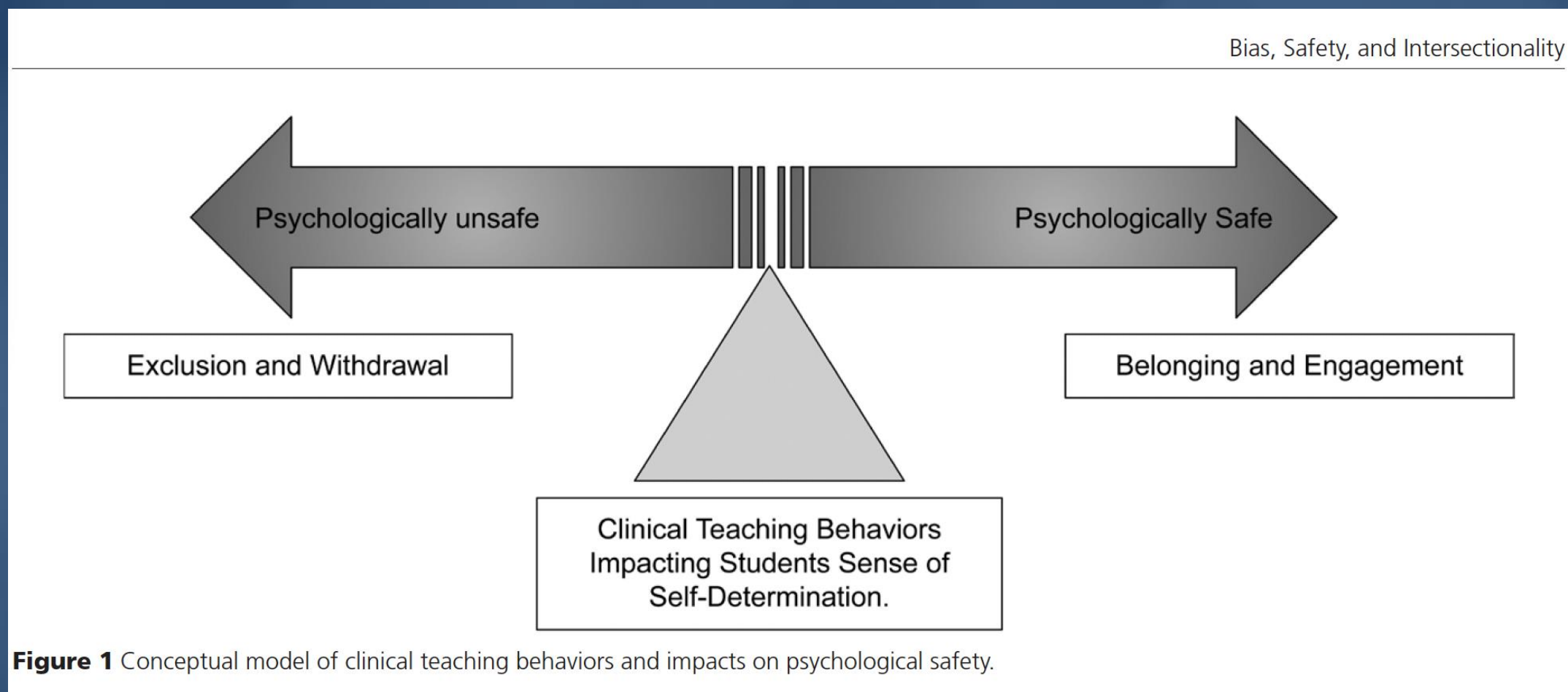
⁴Program Director, Internal Medicine, Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio, USA

Correspondence: Benjamin Kinnear, MD, MEd, Department of Pediatrics, University of Cincinnati College of Medicine, 3333 Burnet Ave, MLC 5018, Cincinnati, OH 45229-3039.
Email: kinneabn@ucmail.uc.edu; Twitter: @Midwest_MedPeds

Detsky, A. S. (2009). The art of pimping. *Jama*, 301(13), 1379–1381. <https://doi.org/10.1001/jama.2009.247>

Kinnear, B., DeCoursey, B., Caya, T., Baez, J., & Warm, E. J. (2022). Things We Do for No Reason™: Toxic quizzing in medical education. *Journal of Hospital Medicine*, 17(6), 481–484. <https://doi.org/10.1002/jhm.12846>

What happens when students perceive psychological safety?



Fewer medical errors, improved patient care

Sense of belonging to a team

Learning thrives – students feel empowered, capable of learning, sense of autonomy

Less burnout

What happens in psychologically unsafe environments?

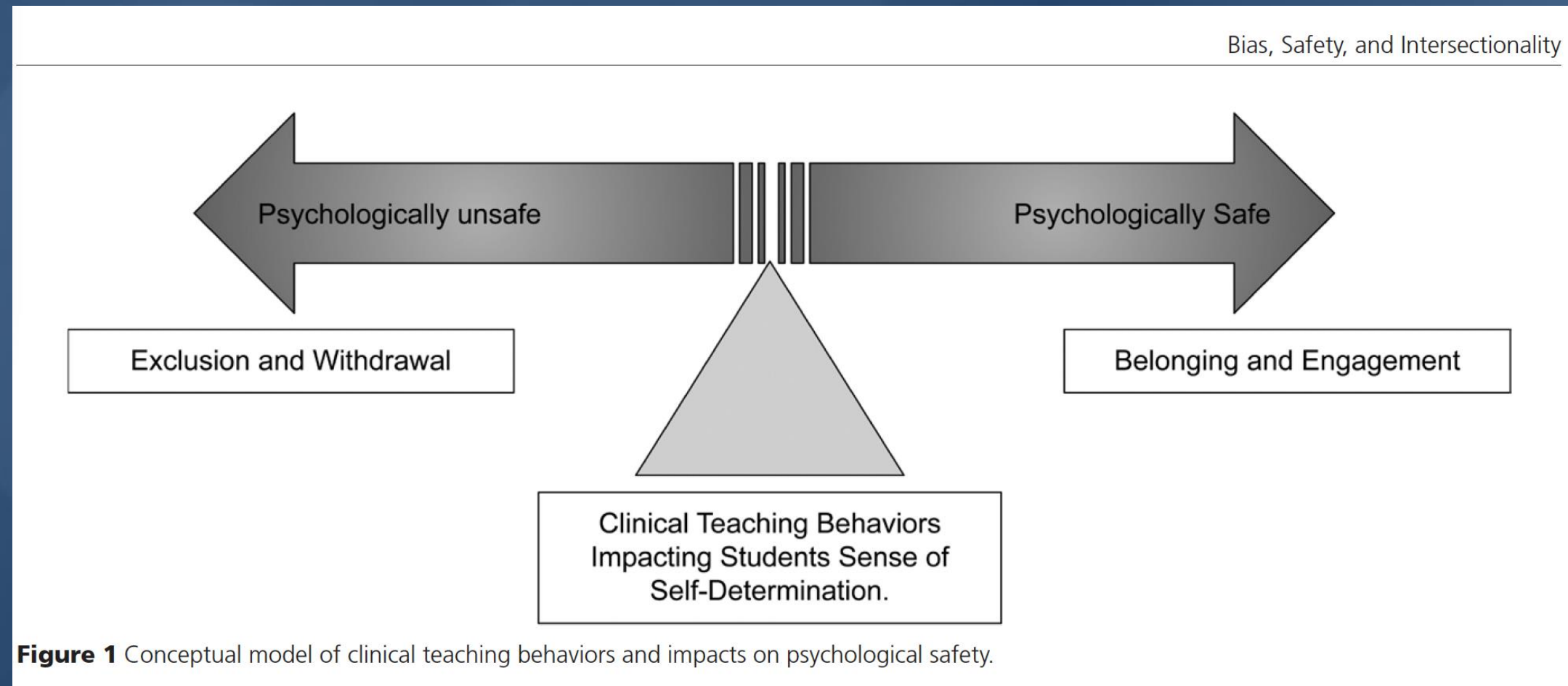
Epidemic of silence – medical errors/near misses, impacts on patient care

Learners withdraw, stop asking questions

Sense of shame, inadequacy, isolation

Inability to learn (or learn on their own) - zone of proximal development

Depression, burnout



How to Build **Psychological Safety** in Medical Education

OBJECTIVES



Define psychological safety and its importance in medical education.



Discuss the specific barriers of psychological safety embedded in the culture of medical training.



Apply strategies on how to improve and develop psychological safety in the clinical environment.

Psychological safety in medical education: A scoping review and synthesis of the literature

Adelaide H. McClintock^a , Tyra Fainstad^b, Kevin Blau^c and Joshua Jauregui^d

^aDepartment of Medicine, University of Washington School of Medicine, Seattle, WA, USA; ^bDepartment of Medicine, University of Colorado School of Medicine, Aurora, CO, USA; ^cDepartment of Medicine, University of Washington School of Medicine, VA Puget Sound Health Care System, Seattle, WA, USA; ^dDepartment of Emergency Medicine, University of Washington School of Medicine, Seattle, WA, USA

ABSTRACT

Purpose: Psychological safety (PS) is the belief that the environment is safe for risk taking. Available data point to a lack of PS in medical education. Based on literature in other fields, PS in clinical learning environments (CLEs) could support trainee well-being, belonging, and learning. However, the literature on PS in medical education has not been broadly assessed.

Materials and methods: In 2020, authors searched PubMed, Web of Science, CINAHL, Scopus, ERIC, PsycInfo, and JSTOR for articles published prior to January 2020. Authors screened all search results for eligibility using specific criteria. Data were extracted and thematic analysis performed.

Results: Fifty-two articles met criteria. The majority focused on graduate medical education (45%), and 42% of studies took place within a CLE. Articles addressed organizational and team level constructs (58%), with fewer descriptions of specific behaviors of team members that promote or hinder safety. The impacts of safe environments for trainees and patients are areas in need of more exploration.

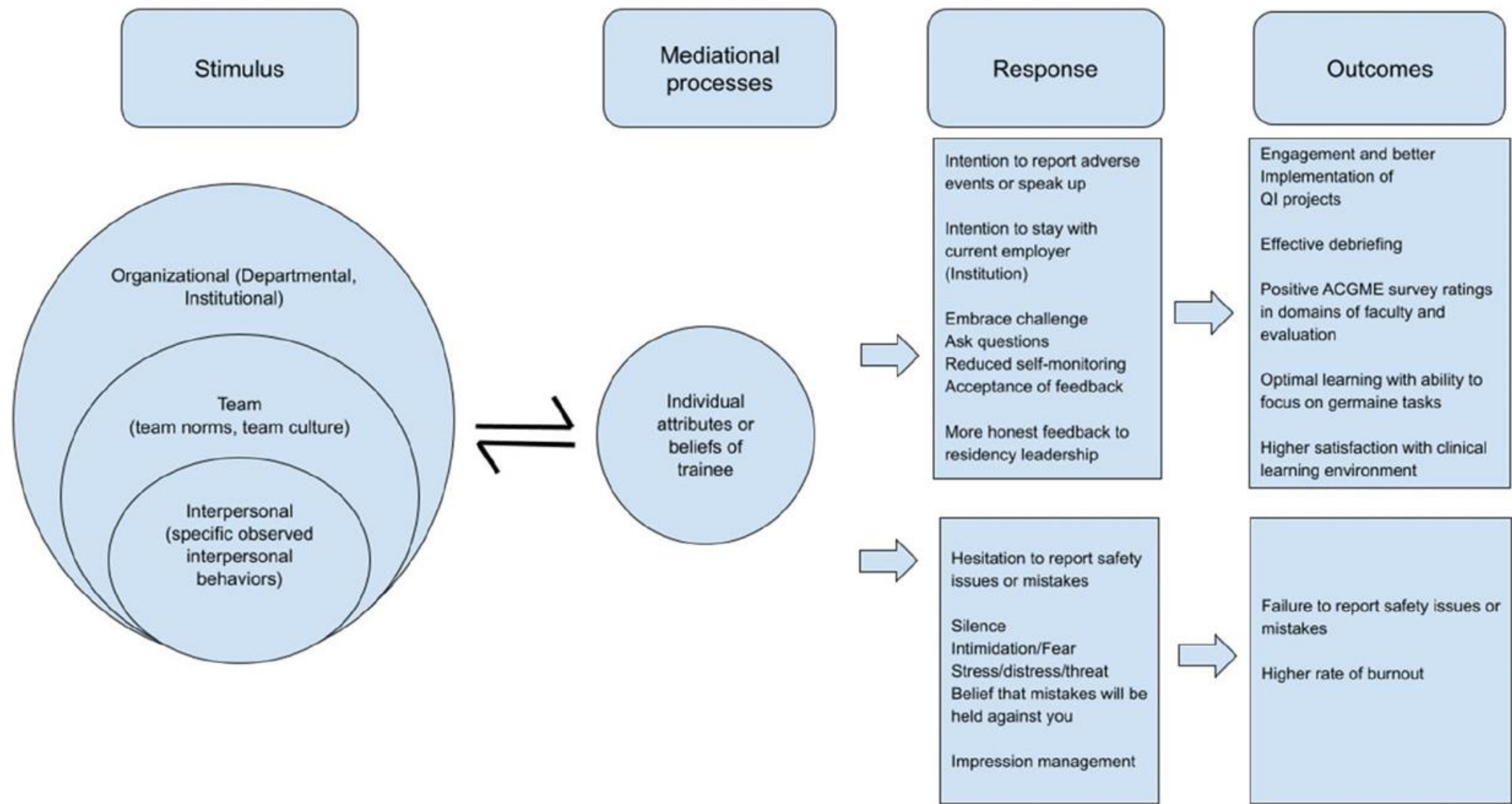
Discussion: Future research should focus on defining specific organizational and interpersonal leader behaviors that promote PS, seek to understand how PS is determined by individual trainees, and measure the impact of PS on learners, learning, and patient care outcomes.

KEYWORDS

Psychological safety; medical education; clinical learning environment; team culture

- 52 articles
- most published since 2016
- focused on medical learners, residents and faculty undergoing CME
- classroom, SIM, clinical environments
- Thematic analysis – 2 theoretical frameworks
- Social ecological model pulls individual out as own entity

Scoping Review – provides background understanding of medical educational structure



What happens in teaching environments?

Figure 2. Synthesis of findings.

Table 2. Tabulation of concepts reported in studies in the 53 articles included in the scoping review.

Theme	Subtheme	Number	%
Organizational factors	Perceived organizational support, organizational factors impacting PS	18	34
Team	Team leader behaviors, hierarchy/power imbalance, collaboration, leader mindset, speaking up about patient safety.	31	58
	Description of leadership structure or imposed/flattened social hierarchy, naming of specific observed behaviors that promote or hinder PS		
Learner attributes		0	0
Learner mediating processes	Descriptions of how learners appraise an environment and make decisions about safety by direct inquiry of learners	1	2
Learner response	Team members engaging in specific behaviors such as asking a question, disclosing a knowledge gap, or speaking up	18	34
Outcomes	Patient safety, educational experience, validation of measures	13	25

N: number of studies per theme; %: percentage of total studies for the associated theme.



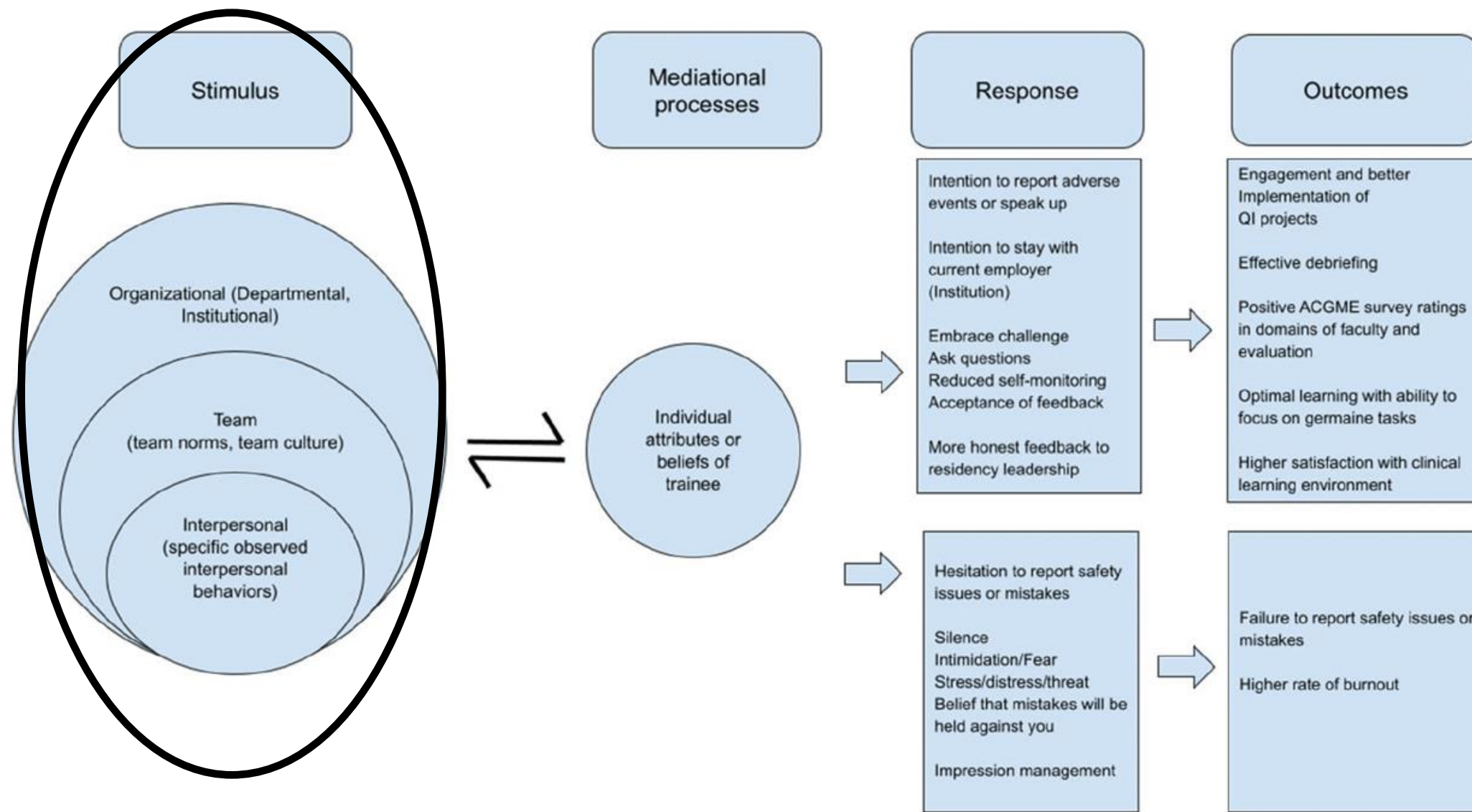


Figure 2. Synthesis of findings.

Table 2. Tabulation of concepts reported in studies in the 53 articles included in the scoping review.

Theme	Subtheme	Number	%
Organizational factors	Perceived organizational support, organizational factors impacting PS	18	34
Team	Team leader behaviors, hierarchy/power imbalance, collaboration, leader mindset, speaking up about patient safety.	31	58
	Description of leadership structure or imposed/flattened social hierarchy, naming of specific observed behaviors that promote or hinder PS		
Learner attributes		0	0
Learner mediating processes	Descriptions of how learners appraise an environment and make decisions about safety by direct inquiry of learners	1	2
Learner response	Team members engaging in specific behaviors such as asking a question, disclosing a knowledge gap, or speaking up	18	34
Outcomes	Patient safety, educational experience, validation of measures	13	25

N: number of studies per theme; %: percentage of total studies for the associated theme.

STIMULUS (organizational factors that impact PS)

- Layered/nested
- Organization – hospital, or health care authority policies/schedules/influences
- Hospital care team culture
- Team members structures and interaction



ORGANIZATIONS/TEAM STRUCTURE/TEAM INTERPLAY

Lack of psychological safety may be linked to:

- Hierarchical structure, part of a large institution – lack of support/intimidation → attending, senior resident, junior resident, nurse, medical student
- High stakes trying to minimize errors affecting patient care, and high paced → culture of blame? quality improvement?
- Complex health systems – ambiguous outcomes
- Teaching and learning founded on teamwork and interpersonal communication & dynamics → disrespectful?
- Assessment component to clinical learning environments → image management



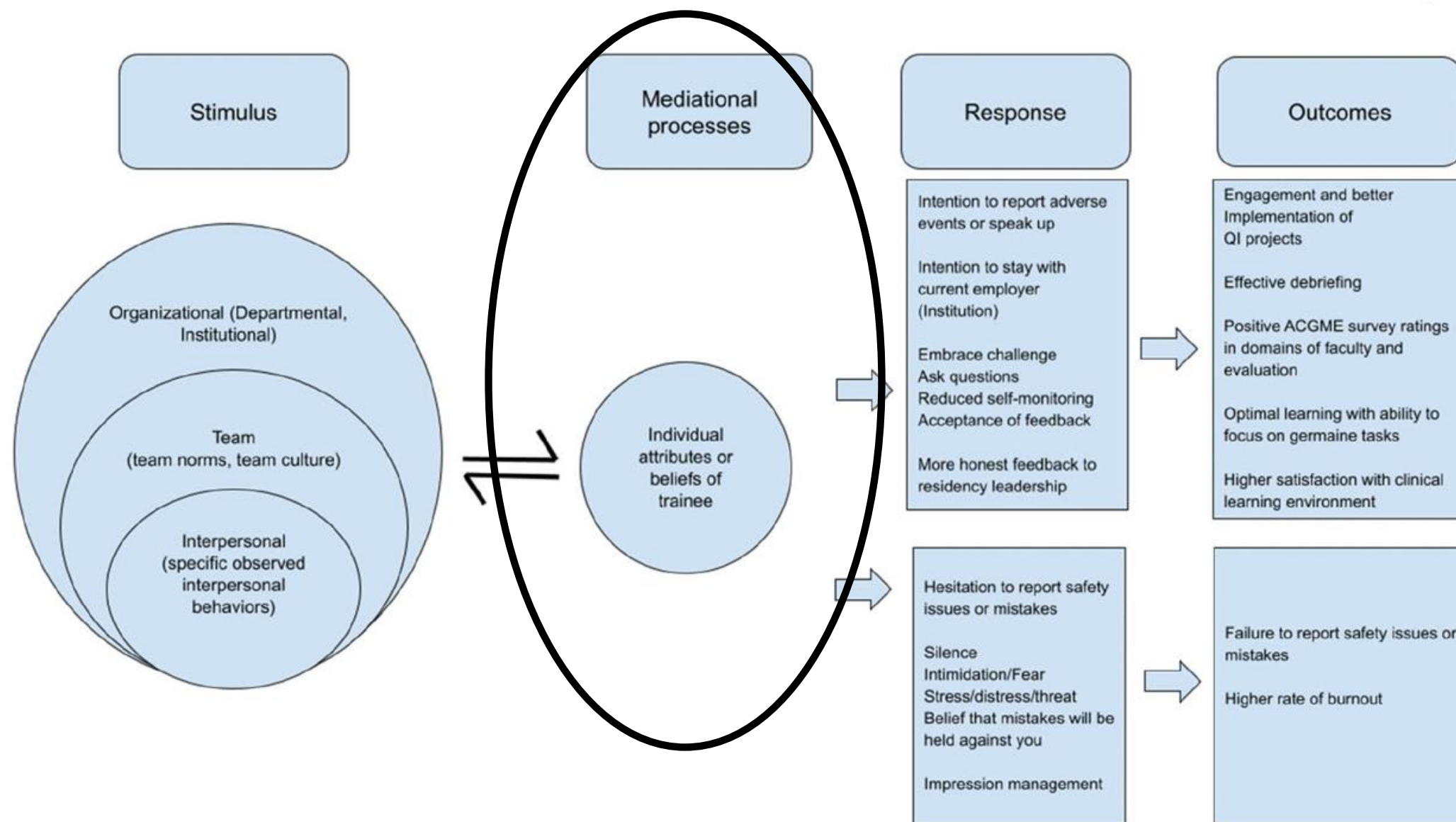


Figure 2. Synthesis of findings.

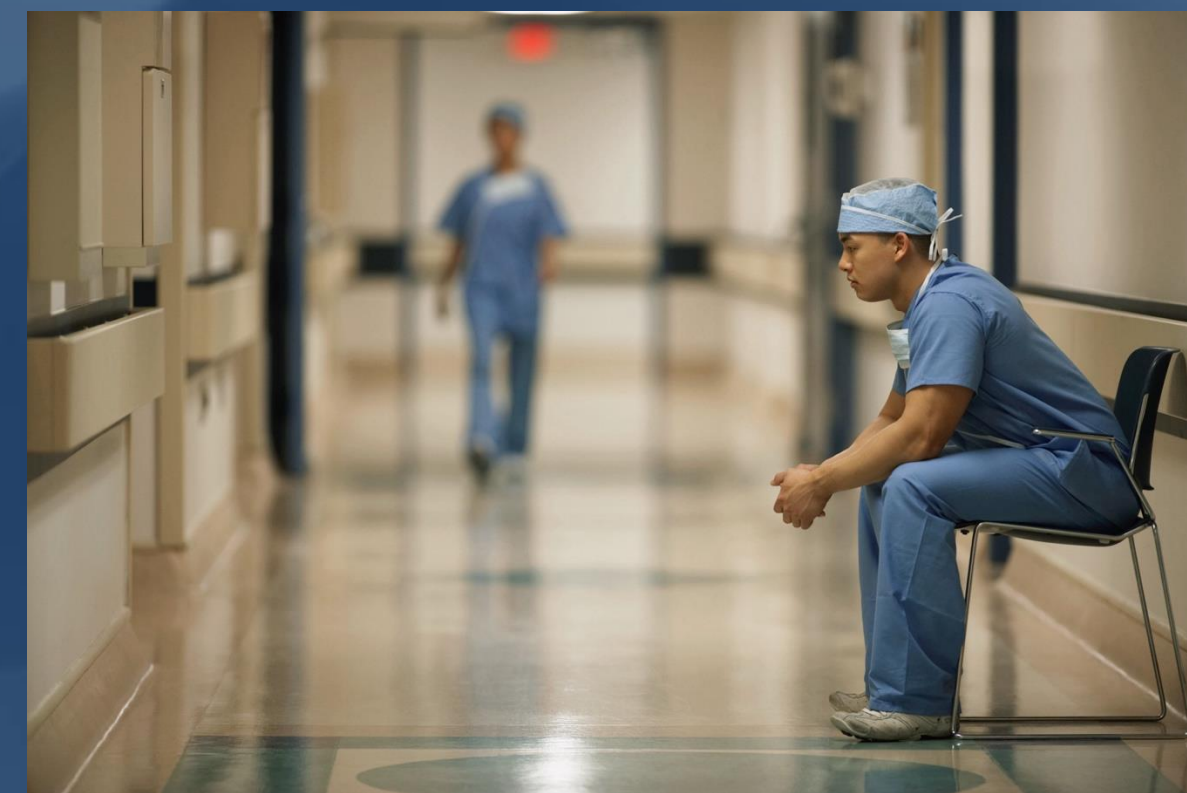
Table 2. Tabulation of concepts reported in studies in the 53 articles included in the scoping review.

Theme	Subtheme	Number	%
Organizational factors	Perceived organizational support, organizational factors impacting PS	18	34
Team	Team leader behaviors, hierarchy/power imbalance, collaboration, leader mindset, speaking up about patient safety.	31	58
	Description of leadership structure or imposed/flattened social hierarchy, naming of specific observed behaviors that promote or hinder PS		
Learner attributes		0	0
Learner mediating processes	Descriptions of how learners appraise an environment and make decisions about safety by direct inquiry of learners	1	2
Learner response	Team members engaging in specific behaviors such as asking a question, disclosing a knowledge gap, or speaking up	18	34
Outcomes	Patient safety, educational experience, validation of measures	13	25

N: number of studies per theme; %: percentage of total studies for the associated theme.

MEDIATIONAL PROCESSES

- Individual trainee – may have attributes/beliefs
- + PS → self-compassion, feel valued and respected, agreeableness
- - PS → neuroticism, fear of judgement, worry of reputation, Hx of mistreatment



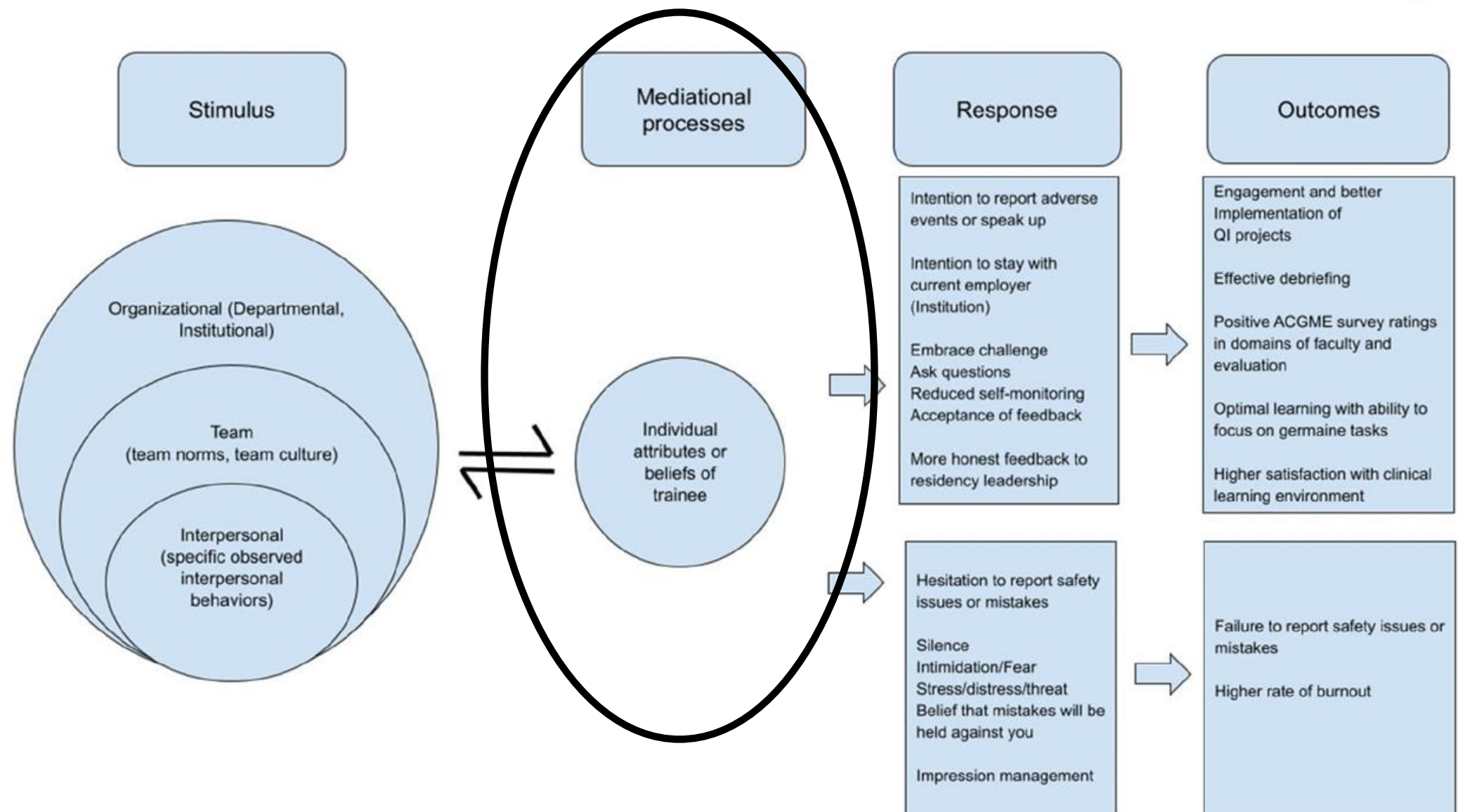


Figure 2. Synthesis of findings.

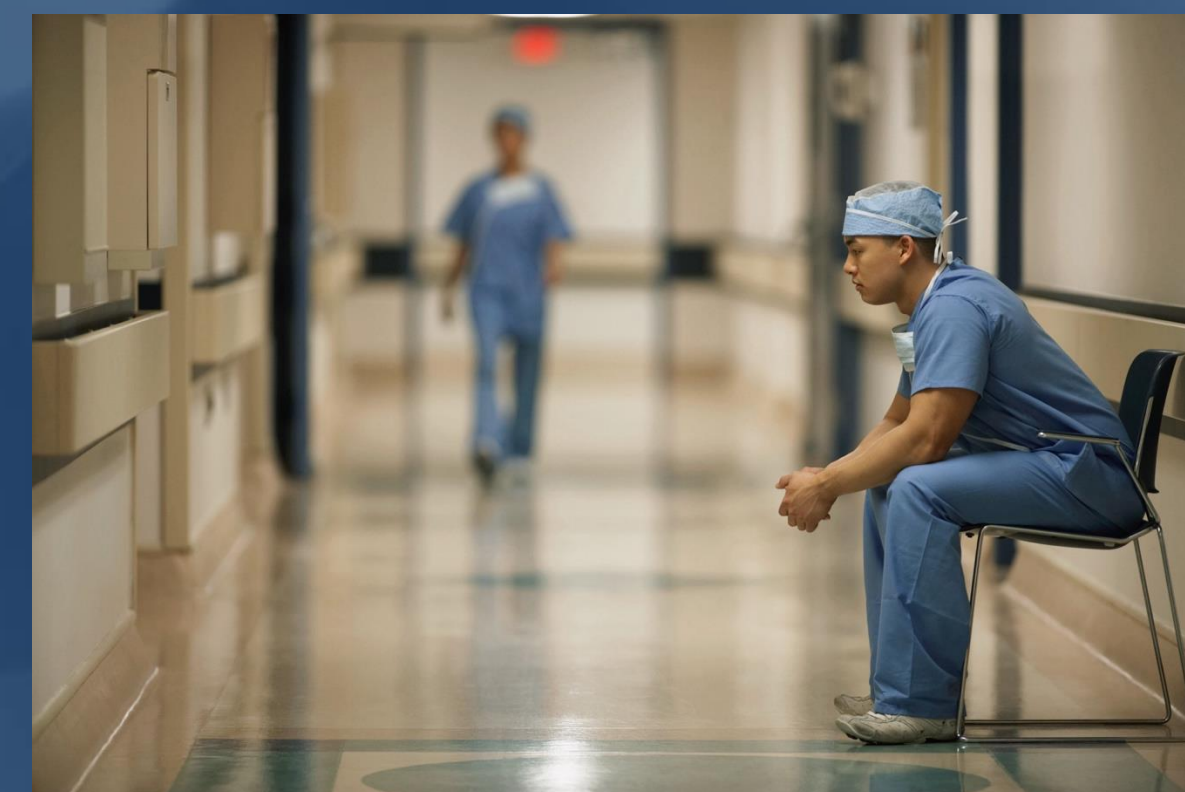
Table 2. Tabulation of concepts reported in studies in the 53 articles included in the scoping review.

Theme	Subtheme	Number	%
Organizational factors	Perceived organizational support, organizational factors impacting PS	18	34
Team	Team leader behaviors, hierarchy/power imbalance, collaboration, leader mindset, speaking up about patient safety.	31	58
	Description of leadership structure or imposed/flattened social hierarchy, naming of specific observed behaviors that promote or hinder PS		
Learner attributes		0	0
Learner mediating processes	Descriptions of how learners appraise an environment and make decisions about safety by direct inquiry of learners	1	2
Learner response	Team members engaging in specific behaviors such as asking a question, disclosing a knowledge gap, or speaking up	18	34
Outcomes	Patient safety, educational experience, validation of measures	13	25

N: number of studies per theme; %: percentage of total studies for the associated theme.

MEDIATIONAL PROCESSES

- Quickly appraise environment and make decision about safety
- Evidence shows trainees seldom change their mind
- First impressions count!!!



INDIVIDUAL ATTRIBUTES....cont'd

- Impression management (protect selves from embarrassment, ridicule, shame → cognitive load)
- High stakes – grade assigned, linked to future career/CaRMS application
- Often learners are 'lowest' rank, in group setting where others are watching
- Complex work, usually as member or team, with uncertainty/ambiguity – less controlled environment
- Cognitive apprenticeship – learn skills through role models, coaching, scaffolding – reflection – interpersonal risks more apparent
- Hidden curriculum → model intelligence, meticulousness, professional identity formation, becoming leaders



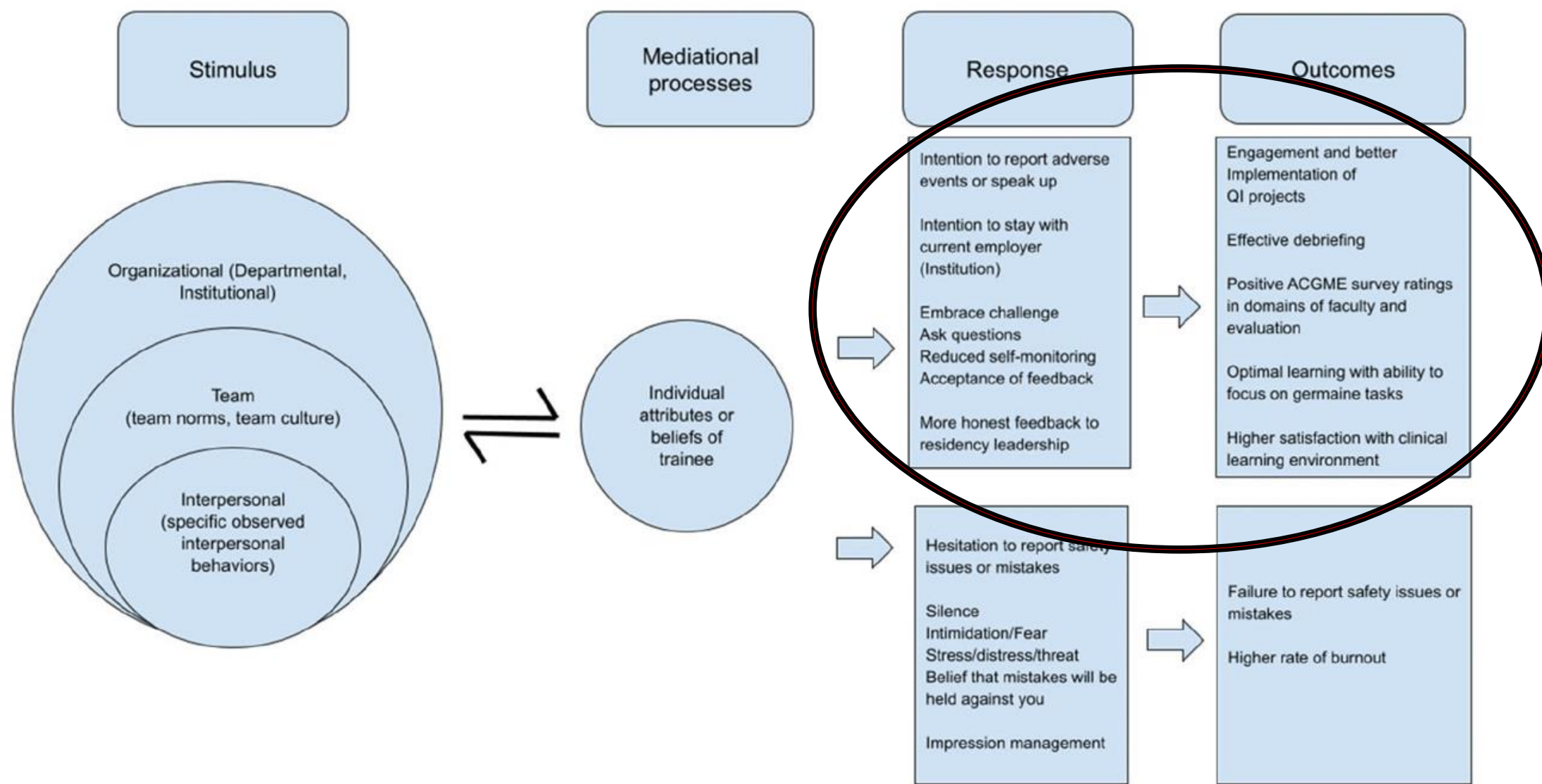


Figure 2. Synthesis of findings.

Table 2. Tabulation of concepts reported in studies in the 53 articles included in the scoping review.

Theme	Subtheme	Number	%
Organizational factors	Perceived organizational support, organizational factors impacting PS	18	34
Team	Team leader behaviors, hierarchy/power imbalance, collaboration, leader mindset, speaking up about patient safety.	31	58
	Description of leadership structure or imposed/flattened social hierarchy, naming of specific observed behaviors that promote or hinder PS		
Learner attributes		0	0
Learner mediating processes	Descriptions of how learners appraise an environment and make decisions about safety by direct inquiry of learners	1	2
Learner response	Team members engaging in specific behaviors such as asking a question, disclosing a knowledge gap, or speaking up	18	34
Outcomes	Patient safety, educational experience, validation of measures	13	25

N: number of studies per theme; %: percentage of total studies for the associated theme.

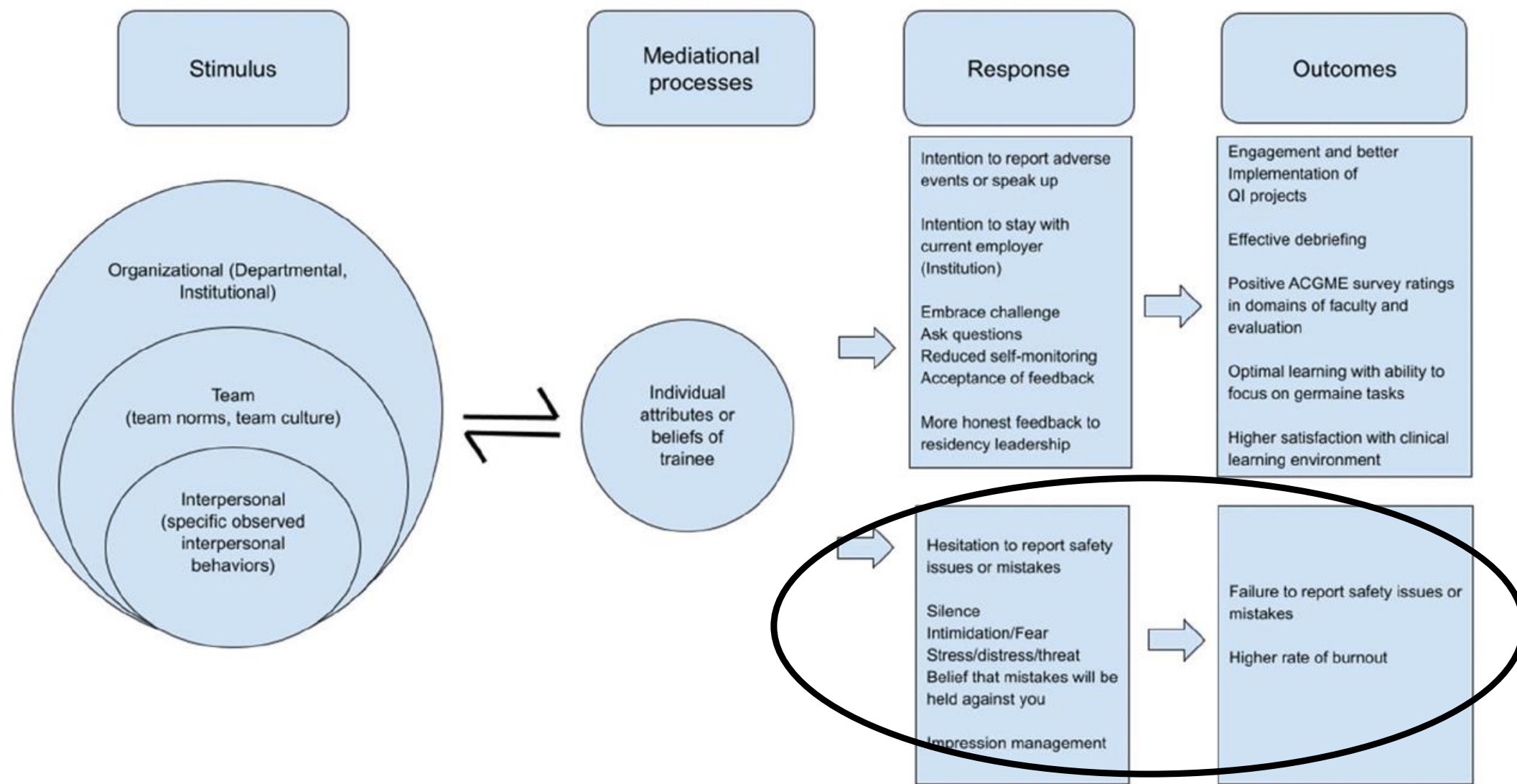
RESPONSE +PS

- Asks questions
- Speaks up
- Intention to stay (retention)
- Embraces challenge
- Provides honest feedback



OUTCOMES +PS

- Engagement
- Optimal learning
- Higher satisfaction of learning environment
- Reduced errors/better patient care



RESPONSE - LACK OF PS

- Hesitate to report issues/errors
- Silence/Intimidation/fear
- Belief that mistakes held against you
- IMPRESSION MGT

OUTCOMES – LACK OF PS

- Failure to report safety issues impacting patient care
- Higher rate of burnout
- Decreased learning because of cognitive load/self protection

Figure 2. Synthesis of findings.

Table 2. Tabulation of concepts reported in studies in the 53 articles included in the scoping review.

Theme	Subtheme	Number	%
Organizational factors	Perceived organizational support, organizational factors impacting PS	18	34
Team	Team leader behaviors, hierarchy/power imbalance, collaboration, leader mindset, speaking up about patient safety.	31	58
	Description of leadership structure or imposed/flattened social hierarchy, naming of specific observed behaviors that promote or hinder PS		
Learner attributes		0	0
Learner mediating processes	Descriptions of how learners appraise an environment and make decisions about safety by direct inquiry of learners	1	2
Learner response	Team members engaging in specific behaviors such as asking a question, disclosing a knowledge gap, or speaking up	18	34
Outcomes	Patient safety, educational experience, validation of measures	13	25

N: number of studies per theme; %: percentage of total studies for the associated theme.

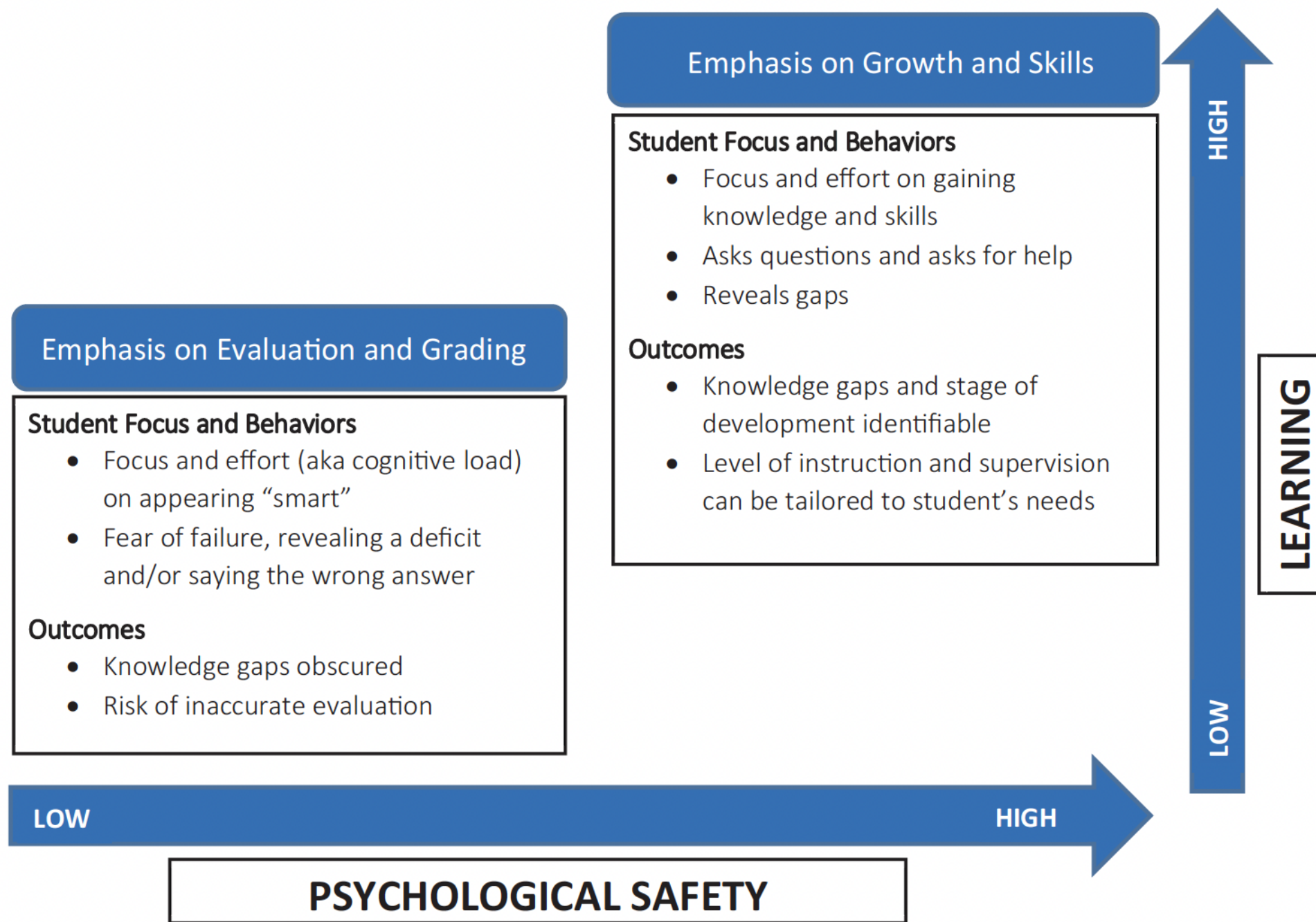


FIGURE 1 Psychological safety and its impact on learning: shifting the emphasis from evaluation and grading toward an emphasis on growth and skills building.

How to Build **Psychological Safety** in Medical Education

OBJECTIVES



Define psychological safety and its importance in medical education.



Discuss the specific barriers of psychological safety embedded in the culture of medical training.



Apply strategies on how to improve and develop psychological safety in the clinical environment.

3 Key Leadership Tasks (medical educators in your team)

1. **Set the stage** – define purpose, set expectations and ground rules, destigmatize failure and risk
2. **Invite participation** – emphasize input from all team players, listen, demonstrate humility/openness to change
3. **Respond productively** – express appreciation, offer help, consider next steps

3 Key Leadership Tasks – Set the stage

- Begins upon arrival of learner to clinical environment
- Get to know your learner – acknowledge, build a relationship
- ‘frame the work’ – set expectations (roles, responsibilities)
- Objectives of rotation → learning objectives of your learner
- Discuss how feedback will be given (feedback is best given with clear expectations at beginning!)

3 Key Leadership Tasks – Set the stage

Psychological Safety Leadership Task #1: Setting the Stage

Case Example 1: New student joins the clinical team for a month-long rotation

Guiding Principles and Conveyed Messages

Suggested Language

Frame the Work:

- Frame the student's role and specific tasks within the team.
- Review the learning objectives specific to the clinical learning environment.
- Encourage students to identify related, individual learning goals.

Emphasize the Purpose:

- Share the teaching intent behind your actions as an educator.
- Explain that it is important to identify and recognize knowledge gaps to learn.
- Explicitly state the importance of learning for all team members.

I think this setting is a good place for students to learn the skills of A, B, and C.

Your role on the team will be X, Y, and Z, and my goal for you at the end of the rotation is [expected level of understanding or competency]. What specific goals do you have for the rotation, and how can I help you achieve these?

I ask a lot of questions and give a lot of feedback to everyone on the team. This is so I know what I can teach you while you are here. It's always OK if you don't know an answer. Everyone is here to learn, including me.

The feedback I give is to support growth towards independence for learners at every level. My main goal is for everyone to learn as much as possible and to enjoy their time here, even if you aren't going into pediatrics.

3 Key Leadership Tasks – Invite Participation

- Encourage learners to speak up, seek input for decision-making – flatten hierarchy (team/values)
- Use open-ended questions, so students can demonstrate what they know
- Model humility, demonstrate mindset of lifelong learning, signal that knowledge gaps are part of growth process – learning TOGETHER
- Provide autonomy (students can demonstrate their skills/knowledge)
- Use inquiry to build knowledge (not highlight gaps)

3 Key Leadership Tasks – Invite Participation

Psychological Safety Leadership Task #2: Inviting Participation

Case Example 2: A student asks you a question to which you don't know the answer

Guiding Principles and Conveyed Messages

Suggested Language

Model Humility and a Growth Mindset:

- Acknowledge gaps in one's own learning and highlight the role of practice for building competency.
- Actively seek input from group members.

I don't know the answer to that question. Do any of you have ideas? Let's look it up together.

What has been the experience of other team members?

Learning X took me a long time, and after 10 years as a pediatrician, I'm still working on it.

Provide Autonomy:

- Make intentional choices about patient care opportunities so that students can demonstrate skills and autonomy.
- Allow opportunities for varying degrees of autonomy that are in line with their stage of development.

Patient A's exam has several common findings associated with illness B.

Let's have you see that patient today. Do what you can based on what you know, and I will help to finalize the plan.

Now that you have seen the patient, what are your recommendations? If you don't know, that's okay. Let's start with concerns that you have identified.

You go first, and I can add some tips based on other cases that I have seen.

Use Inquiry to Build Knowledge, Not Highlight Gaps:

- Show curiosity and ask "why" questions to promote critical thinking.
- Refrain from asking questions based on knowledge recall.
- To avoid placing a student in a position where they may feel humiliated for not knowing an answer, consider directing questions to the group.

Can anybody tell us why we see these exam findings in a patient with disease C? [rather than asking an individual student: What are the 3 classic exam findings in patients with disease C?]

Tell me why you think medication Y may be useful in treating this patient's symptoms?

3 Key Leadership Tasks – Respond Productively

- Reward growth over performance, highlight accomplishments & contributions
- Destigmatize failure
- Offer future oriented feedback
- Offer specific coaching toward learning goals
- Feedback oriented toward learning (SMART feedback)

3 Key Leadership Tasks – Respond Productively

Psychological Safety Leadership Task #3: Responding Productively

Case Example 3: A student proposes a treatment plan you think is not clinically indicated

Guiding Principles and Conveyed Messages

Suggested Language

Express Appreciation:

- Acknowledge what is “right” about the answer.
- Work towards understanding where the suggested plan diverged from a more appropriate plan by asking questions.
- Provide a decision-making framework and clinical rationale for the preferred plan.

Nice presentation and good work committing to a plan.

I know it can be hard when there are so many issues going on. I think you are right; we need to treat X with Y intervention.
Can you tell me more about how you chose Y intervention?

Destigmatize Failure:

- Offer feedback and recommendations that are based on direct observation and oriented toward next steps.

I can see how you chose Y intervention. I would usually choose Z intervention here because [provide your own clinical reasoning and decisionmaking framework].

One resource I find helpful for X is [point towards specific reading or skill practice opportunity].

Getting away from **Pimping** → Art of questioning

Received: 7 January 2022 | Accepted: 21 April 2022

DOI: 10.1002/jhm.12846

CHOOSING WISELY®: THINGS WE DO FOR NO REASON™

Journal of
Hospital Medicine **shm.**
Society of Hospital Medicine

Things We Do for No Reason™: Toxic quizzing in medical education

Benjamin Kinnear MD, MEd^{1,2} | Bailey DeCoursey¹ | Teresa Caya MD³ |
Javier Baez MD² | Eric J. Warm MD⁴

¹Department of Pediatrics, Cincinnati Children's Hospital Medical Center, University of Cincinnati College of Medicine, Cincinnati, Ohio, USA

²Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio, USA

³Resident (PGY-4), Internal Medicine and Pediatrics, Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio, USA

⁴Program Director, Internal Medicine, Department of Internal Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio, USA

Correspondence: Benjamin Kinnear, MD, MEd, Department of Pediatrics, University of Cincinnati College of Medicine, 3333 Burnet Ave, MLC 5018, Cincinnati, OH 45229-3039.

Email: kinneabn@ucmail.uc.edu; Twitter: @Midwest_MedPeds

- What is the GOAL of quizzing learners?
- Eliminate strategies that reinforce hierarchy & intimidation
- Reinforce knowledge gaps as learning opportunities (not deficits to hide)
- Ask questions where you don't know answer – role model curiosity, self-directed learning, humility

Kinnear, B., DeCoursey, B., Caya, T., Baez, J., & Warm, E. J. (2022). Things We Do for No Reason™: Toxic quizzing in medical education. *Journal of Hospital Medicine*, 17(6), 481–484. <https://doi.org/10.1002/jhm.12846>

BUILDING PSYCHOLOGICAL SAFETY IN MEDICAL EDUCATION - SUMMARY

BE AWARE OF BARRIERS to PS

- High work-loads, time pressures
- emphasis on performance and grades
- Lack continuity with learners
- Culture of blame, intimidation, hierarchy

LEARNER ATTRIBUTES

- Get to know your learner
- Resiliency - Past learning experiences
- Image management – cognitive load that affects learning
- First impressions count!

BUILD PSYCHOLOGICALLY SAFE TEAMS

- High quality relationship amongst team members
- Emphasis on interdependence & teamwork
- Humble leaders who invite & ask for input, treats members with respect, flatten hierarchy

BENEFITS TO LEARNERS

- Fewer medical errors, improved patient care
- Sense of belonging to a team
- Learning thrives – students feel empowered, capable of learning, sense of autonomy
- Less burnout/improved retention

How to Build **Psychological Safety** in Medical Education

OBJECTIVES



Define psychological safety and its importance in medical education.



Discuss the specific barriers of psychological safety embedded in the culture of medical training.



Apply strategies on how to improve and develop psychological safety in the clinical environment.

How to Build Psychological Safety in Medical Education

Lillian Au

lla@ualberta.ca



References

- Bump, G. M., & Cladis, F. P. (n.d.). Psychological Safety in Medical Education , Another Challenge to Tackle ? *Journal of General Internal Medicine*, (0123456789), 41–45. <https://doi.org/10.1007/s11606-024-09166-y>
- Chen, J. H., Pradarelli, A. A., Evans, J., Matusko, N., Naughton, N. N., Phitayakorn, R., & Mullen, J. T. (2025). *Barriers and Facilitators to Surgical Trainee Psychological Safety*. 8(9), 1–12. <https://doi.org/10.1001/jamanetworkopen.2025.34462>
- Detsky, A. S. (2009). The art of pimping. *Jama*, 301(13), 1379–1381. <https://doi.org/10.1001/jama.2009.247>
- Grailey, K. E., Murray, E., Reader, T., & Brett, S. J. (2021). *The presence and potential impact of psychological safety in the healthcare setting : an evidence synthesis*. 6, 1–15.
- Id, K. G., Lound, A., Murray, E., & Id, S. J. B. (2023). *The influence of personality on psychological safety , the presence of stress and chosen professional roles in the healthcare environment*. 1–20. <https://doi.org/10.1371/journal.pone.0286796>
- Kinnear, B., DeCoursey, B., Caya, T., Baez, J., & Warm, E. J. (2022). Things We Do for No Reason™: Toxic quizzing in medical education. *Journal of Hospital Medicine*, 17(6), 481–484. <https://doi.org/10.1002/jhm.12846>
- McClintock, A. H., Fainstad, T., Blau, K., & Jauregui, J. (2023). Psychological safety in medical education: A scoping review and synthesis of the literature. *Medical Teacher*, 45(11), 1290–1299. <https://doi.org/10.1080/0142159X.2023.2216863>
- McClintock, A. H., Kim, S., & Chung, E. K. (2022). Bridging the Gap Between Educator and Learner: The Role of Psychological Safety in Medical Education. *Pediatrics*, 149(1), 1–4. <https://doi.org/10.1542/peds.2021-055028>
- Mcclintock, A. H., Fainstad, T. L., & Jauregui, J. (2022). Clinician Teacher as Leader: Creating Psychological Safety in the Clinical Learning Environment for Medical Students. *Academic Medicine*, 97(11), S46–S53. <https://doi.org/10.1097/ACM.0000000000004913>
- Graduation Questionnaire National Report 2024*.
- Ridley, C. H., Al-hammadi, N., Maniar, H. S., Abdallah, A. Ben, Steinberg, A., Bollini, M. L., ... Avidan, M. S. (2021). Building a Collaborative Culture : Focus on Psychological Safety and Error Reporting. *The Annals of Thoracic Surgery*, 111(2), 683–689. <https://doi.org/10.1016/j.athoracsur.2020.05.152>
- Torralba, K. D., Jose, D., & Byrne, J. (2020). Psychological safety, the hidden curriculum, and ambiguity in medicine. *Clinical Rheumatology*, 39(3), 667–671. <https://doi.org/10.1007/s10067-019-04889-4>
- Wawersik, D. M., Jr, E. R. B., Gore, T., Palaganas, J. C., Wawersik, D. M., Jr, E. R. B., ... Palaganas, J. C. (2023). *Individual Characteristics That Promote or Prevent Psychological Safety and Error Reporting in Healthcare : A Systematic Review Individual Characteristics That Promote or Prevent Psychological Safety and Error Reporting in Healthcare : A Systematic Review*. 3201. <https://doi.org/10.2147/JHL.S369242>

THANK YOU!

PLEASE FILL OUT YOUR SESSION

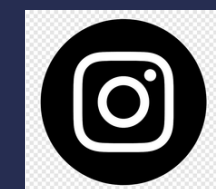
EVALUATION NOW!



FOLLOW US



FamilyMedicineForum



FamilyMedForum