Trauma-Informed Medical Education with Dr. Jennifer Potter

[Intro Music]

Amanda Garza: Welcome to CLIME Cast. I'm Amanda Garza, the CLIME Program Manager. In today's episode, we are excited to bring you a conversation between CLIME Associate Director Kate Mulligan and Dr. Jennifer Potter on the topic of trauma-informed care and medical education. Before we dive in, here's a bit about our guest.

Dr. Jennifer Potter is a professor of medicine at Harvard Medical School in a national leader in trauma-informed care for women and sexual and gender minority communities, as well as trauma-informed medical education.

Dr. Potter helped develop the first undergraduate medical education competencies in trauma-informed care and sexual and gender minority health. At Harvard, she serves as advisory dean and the director of the William b Castle Society and is also an associate director of two CME courses and faculty co-director of two longitudinal curricular themes focused on trauma-informed care and sexual and gender minority health equity.

She also serves as an associate editor for MedEd Portal and consults nationally on health equity initiatives. Her many honors include the Harold Amos Faculty Diversity Award and the Double AMC's Individual Leadership Award for Women in Medicine and Science. We hope you enjoy this episode

Kate Mulligan: Welcome Dr. Potter thank you so much for joining us today. I'm really excited for the opportunity to speak with you after your Grand Rounds presentation at UW, which we have linked at the CLIME website. That was a brilliant and very well received presentation, and I thought it'd be great to have a chance to talk to you maybe a little bit more informally or a little bit more in depth or tangentially about some aspects of trauma informed medical education.

So thank you thank you for the opportunity to chat with you. Yeah. Yeah. So I thought often we start our podcast with having our speaker or our guest tell a little bit about their journey, their medical journey and the path that brought you to where you are now. And what inspired you and your focus on trauma informed teaching?

Jennifer Potter: Absolutely. I think that there, there are three major things that have inspired my interest in this topic. I'm a primary care clinician and very early on, even in residency training, even in medical school, actually, I started to notice, Different stories that patients were bringing that had me start thinking about needing a different kind of approach that that I even in my mind started thinking about as a trauma informed approach and my practice, it focuses on women's health plus health and people who have had cancer with intersections between those different groups and early on in the history, obtaining part of an interaction.

And I notice that people would tell me that they would start to experience palpitations when they got within a half a mile of the medical center, because this was where they had come every 3 weeks for their chemotherapy, and it was just scary. So their bodies were holding that fear or during an examination, even with the transparency of letting somebody know that I was going to reach behind with my stethoscope and apply it to the chest and listen to their lung sounds because they were coming in with a cough when I placed the stethoscope on the skin, there could be a startle response.

And I started to just, uh, you know, sort of work with people in a different manner with with more, anticipatory guidance and really just spending more time and presence before moving on into aspects of the encounter that could potentially be reactivating. And that seemed to help. And then as I proceeded in teaching and advising medical students and residents, I started to notice some similar things.So, what was coming up was that increasingly because of wanting to welcome students in from all backgrounds because they bring such rich lenses that are only going to enhance patient care for the diverse populations that we're serving. We also were seeing increasing numbers of people who themselves had a lot of distance traveled and many are incredibly resilient and many are still in their own journeys of healing and recovery, and so, as they were starting to experience some of the traumatic things that just happen naturally in medical education, things like receiving a trauma disclosure from a patient for the 1st time things like learning how to perform a very sensitive, intimate type of physical exam, like a pelvic exam or a genital exam.

For example, we would notice that we would have 1 or 2 students every year who would just want to avoid these experiences. We would notice that in a teaching session, students might appear to be very distracted or just not engaged with the topic and then sometimes we would notice a more, you know, sort of kind of fight type of trauma response where a student might be, very actively challenging, our teaching of some of these things.

And so this got me thinking of the about the fact that, many people ubiquitously people experience trauma and adversity. And so this is obviously impacting our, our students as well. And then I guess the other thing I would share is that, reflecting on my own experience across the medical education trajectory, I had a very formative experience working in the ICU as a second year internal medicine resident, where I had a patient came in who had meningococcal meningitis and coded it for a number of hours, because it was [00:06:00] so hard for the team to let her die. And I was the person in charge of that entire experience and the next morning I rotated off the service and there was no. There was no debrief of any kind. I just went off service and I went on vacation with a prescription for and so.

And it was really hard and I, you know, I got support in other places. Fortunately, I, I was pretty well resourced that way, but it took me a very long time to kind of process that whole experience. And it made me realize that there were other ways that this could have been handled and that even in the moment while I was there doing the work that there were some coping strategies I could have invoked even in the, in the heat of the moment. That

would have been helpful to me and maybe to some of the other people long winded explanation. No, those are the stories.

Kate Mulligan: So, so it's interesting. It sounds like you actually came to this point sort of intuitively and personally from the care arena and then just realized that we could apply it to the learning environment and teaching as well.

Um, so, and I, I get the sense that that is how, the philosophy or the approach has blossomed as it's taking the principles from the care environment and applying them to the learning and teaching environment. Is that a fair thing to say?

Jennifer Potter: Yes, that's exactly right. I mean, if you, if you really look at the historical roots of how awareness of the impact of trauma on health came from, it goes way back.

I mean, even, even to the days of Freud, when he was studying women presenting with, you know, hysteria and it turned out that Almost all, if not all of those people that he was studying had experienced incest. So even then the, the underpinning of a health manifestation. Was trauma and move forward even to, I think, World War 1, [00:08:00] where for the 1st time, shell shock was described.

And it really wasn't until much the much more modern era in the 70s, when we had veterans coming back from the Vietnam war that a lot more research was starting to be done around the impact of combat experience. Uh, on mental health with with post traumatic stress disorder in particular, and then fast forward, even just a little bit more into the 90s when the adverse childhood experiences study was published and we started to understand that. It was really an accumulation of traumatic experiences at a very early point in one's growth and development that could lead to lifelong health consequences. And it's so interesting how fields evolved, because now we understand that these adverse experiences have a tremendous potential for causing adverse health impacts. [00:09:00] However, there are also positive experiences many of those that can buffer the negative impact and also create resilience. And so we're starting to understand clinically and I think also in the educational realm, how we need to help people heal and we need to build positive experiences. Both, both are important.

Kate Mulligan: Yes, I think that's one aspect of your Grand Rounds presentation that I really appreciated because I came late to an understanding of ACEs from a, from a basic science perspective, teaching medical students, and I hadn't heard about the buffering effect of positive experiences, although it makes total sense, and it was great to hear that here you say that, you know, we can, we can help in a very concrete way, by creating those sorts of positive experiences in the classroom. So thank you. So let's uh, let's step back a little bit and let's pretend that we've got listeners that have never heard about trauma informed medical education or trauma informed [00:10:00] teaching. How would you define that? Or is there an easy way to define that?

Jennifer Potter: I think that I consistently come back to the Substance Abuse and Mental Health Services Administration's framework for trauma informed care, which is easy to

apply in an educational setting as well, and that framework is based on what are known as the four R's and the six principles, where the four R's include realizing the impact of trauma on health, recognizing signs of trauma in patients, students. Ourselves responding in a trauma informed manner, and then resisting re, traumatization by, by causing more harm, not not doing that. And the 6 principles are, and I'd love to say these out loud, because it sort of centers me every single time. So there's safety, [00:11:00] trustworthiness and transparency peer support collaboration and mutuality empowerment, voice and choice. And addressing cultural, historical, and gender issues. So if we apply these principles and use the lens with the 4Rs and then apply these principles in our work in the medical education environment, we create a space which is conducive to learning.

Essentially, we're creating a positive learning environment that can help people to heal and flourish. And this is really a universal thing. People who need the healing will have that impact. People Who are not currently hurting will be able to benefit too. Mm-Hmm, .

Kate Mulligan: Maybe we can unpack some of those things as we go along, but how would you summarize how trauma might show up in our students?

Like if someone's, actively undergoing some sort of trauma, [00:12:00] what would we look for? I do hear that you're saying that a trauma informed response is going to be good for everybody. And I, I totally agree with that. But there may be some students that are maybe actively in need of some extra help. What things should we look out for?

Jennifer Potter: Yeah, it's a great question. So we know from a lot of the work that's been done to create trauma informed schools, and this is really in early childhood education and, you know, through middle school, maybe up through high school as well. We certainly know a bit about how trauma exposure can adversely impact academic performance and behaviors. The manifestations of trauma in those settings can include any element of the fight light or freeze response. So these are trauma responses that are a physical manifestation of the embodiment of trauma and how it's affecting us physiologically. So, in regard to the fight response, that could involve behaviors like dismissing feedback that a teacher is attempting to provide or refusing assistance, that a person is offering or breaking rules. The flight response could show up as appearing to be distracted or being really off task kind of disconnected with what what the active learning task is or avoidance, just not not showing up physically in the space.

And then the freeze could be appearing to be zoned out, or, maybe even falling asleep in class. So these are trauma responses that all of us actually may manifest and particularly are more likely in people who are really actively grappling with trauma reactions in themselves. I think the important thing is that if you just look at medical students throughout [00:14:00] their M1 through M4, or whatever it turns out to be a trajectory, you actually can see, I mean, first of all, you'll see them enumerate the types of traumatic experiences they're having just in the learning environment and the practice environment because it's hard learning to be a clinician, it's hard being a clinician and there are experiences you have, which will be impactful. And I think because of coming in with maybe not having yet highly,

adapted coping skills. The cumulative effect of these kinds of experiences can lead to shifting from maybe a slightly more adaptive coping style on entry to medical school to a maybe slightly less adaptive one is you get further along and we know that there are higher rates of burnout and depression compared with age matched controls and then decreased engagement. And learning, and for some people who probably carry a higher [00:15:00] trauma burden that can translate into lower test scores and loss of empathy on professional behavior, that sort of thing.

So, I think that all students are potentially impacted and those who have already had a lot of adverse experiences, maybe more so.

Kate Mulligan: Thank you, it's really helpful, I think, especially for new teachers to hear that those behaviors that we might dismiss as, annoying, or, defiant could well be, explained by understanding of their history and, and how, how things like trauma can be manifested in the classroom. I mean, I, I remember early on serving on the student progress committee and there'd be a Dean there saying, well, I've reached out to this student over and over again, and they won't answer my email. And I was kind of like, what, what could that possibly be the case, but,, I think it's helpful to be aware that there could well be, understandable explanations for that kind of a response so thank you for that.

So we've got a framework and we've got some principles, but [00:16:00] maybe you could share with me some other defining characteristics of trauma informed medical education and what are some of the key components. Thanks. That should be included in a trauma informed medical education approach.

Jennifer Potter: Absolutely, I'm thinking about it really is it gets back to very basic 101 level ways of approaching students from the beginning. And some of this teachers will receive training on if they have done diversity, equity and inclusion seminars for example, there's a fair amount of overlap there in the clinical realm patient centered care has a lot of overlap with trauma informed care. So, in the student realm, student centered learning is going to have a lot of overlap too. So, I think in the very beginning, approaching new students, it's really about being curious and welcoming students holistically for who they are, they're, you know, the [00:17:00] holistic sense of their identities and their experiences and respectfully pronouncing their names correctly, asking for their pronouns, that sort of thing. In a classroom, for example, or or on a clerkship, it's about involving students in co creating the ground rules for how this team is going to work together or how this class is going to create a safe space to have discussions about things that can sometimes be challenging. It's about, I think, as the teacher, it's about role modeling vulnerability, letting the learners see that you too were affected by difficult situations that arise and sharing strategies for how you cope in those situations. And here's where bringing in, a panel of near peers to talk about their experiences and then leapfrogging from that to asking the students, how do you think you might respond in a similar circumstance?

And what are some of the strategies you might draw on to deal with [00:18:00] these situations can be helpful. We can't assume that every student walking in the door already

has skills for emotion regulation. And so actually thinking about introducing concepts, like the window of tolerance and teaching students, those skills is really important.

Providing anticipatory guidance is super helpful. We found before commonly potentially distressing experiences, like walking into the gross anatomy lab for the 1st time, or. Conducting an exercise. Learning how to inquire about a trauma history intimate partner violence, for example, or even just sending students out to start learning how to do histories.

They are going to naturally receive trauma disclosures and so helping the students. anticipate that and think about how they might handle it, how they might respond to the patient, how they might then handle themselves because they may [00:19:00] be impacted by hearing that information is helpful. Definitely creating a really respectful atmosphere with boundaries so students are not expected to share personal tidbits that may delve into the trauma arena and Building in just natural breaks during the course of classes that are bringing up this kind of material so students can go to the bathroom, take a walk, stretch, get a snack, do a meditation exercise, whatever they need to do is really great. Um, offering voluntary debriefs is great. I would have loved that after my, I see you experience, for example, and it just wasn't available at the time. And I probably would have taken a faculty member up on that had it been offered, and I probably would have just sobbed, but it would have been great to know that I wasn't alone in the experience of that extremely difficult and that this, that this lovely young human had, [00:20:00] I think also always providing support resources in curricular materials and all that kind of thing goes without saying clarity, just transparency. So important surrounding grading policy. What happens if you need to be absent? Topics that are going to come soon in the curriculum, so that people are prepared for those topics showing up. It's just always easier to manage a trauma response. If you anticipate that you could have one and then we teach still with pure physical exam because of resource limitations and it's important to have guidelines around that and make sure that students have a choice about whom they're going to partner with.

So empowerment, voice, choice, all these things are just so key.

Kate Mulligan: Thank you. I really appreciated the call to developing human relationships with students. I mean, I feel a little bit sad that the shortening of the curriculum in the basic foundational years Has, has impacted our ability to do that successfully.

Personally, I help teach in the anatomy thread, which means I get to see the students periodically throughout that 18 month period. So, we do get to develop a relationship, but for some of the blocks of curricular activities at some WAMI region that, you know, it's a walk on, walk on, walk off sort of teaching experience.

And I don't think I'd survive very well in that environment, but I believe that the clinical side of our training does accomplish the sorts of things that you're talking about. So really, I'm thinking about this podcast as being especially helpful to people in the classroom in the early days, but thank you for sharing all of those tips.

We actually are accumulating a number of resources on the CLIME website that are related to this, this idea of developing relationships and making a healthy learning environment by involving the students in co creating [00:22:00] an environment where we can all thrive and learn from each other in a respectful way.

We had a, we had a podcast with a former faculty member, David Masuda, uh, Who talked about the exact thing that you were mentioning with sharing your failures and your vulnerabilities. And he actually used to have a, I believe he used to have a face plant board where you could just put up, examples of when you'd face planted and, and how you'd survived that.

And I, I think that idea of failing and recovering is something that is well worth emphasizing for our very high achieving, medical students in general.

Definitely. Okay, so I guess another question I think I know the answer to, however, is who should be adopting this strategy of trauma informed education?

And I think the answer is everybody, but maybe you have some subtleties or some nuances that you would like to add to that question.

Jennifer Potter: The answer definitely is, is everybody. I think that There is a tendency for teachers and medical education to [00:23:00] immediately swing toward trauma informed medical education being focused on clinical skills development and it absolutely is.

And our focus obviously is to enhance patient care and make sure that patient care is safe and proceeding the way it always should. But I think that It's really important to think about our learning environment very broadly and that we, we need to provide a space where it's really a crucible in which our learners are supported and are able to grow in the wholeness of their clinical skills, remembering that a skilled clinician is also skilled at managing their own internal responses and needs to understand something about how stress impacts is going to impact them as a clinician in the every day of their work and notice [00:24:00] the signs that that is starting to happen and maybe they're getting outside their own window of tolerance.

Know what types of strategies they can use to kind of move back in it in order to be safe. Healthier, more clear of mind and better able to engage with a patient in a productive way. So, we've really found it most helpful to frame trauma, inform medical education as. Clinical skills for the students, because otherwise we, we lose maybe 25 to 30 percent who hear emotion regulation and it sounds very soft skills to them.

And they don't really understand the connection yet. Between that internal piece and how very important it is to how well you're actually going to be able to function as a doctor.

Kate Mulligan: Yeah, I think you're getting it another question I had lined up, which was what are the pitfalls or the challenges in implementing trauma informed [00:25:00] medical education?

And I'm guessing that student resistance is 1 of them. Are there other ones or would you like to elaborate more on that?

Jennifer Potter: Uh, yeah, for sure. So, yeah, I think student openness to this whole concept is definitely 1 piece of it. And so it's very important to. Attach the learning of the skills to. Something very practical that the student understands that they need to be able to do as a clinician.

I also think this is where having co teachers is so important. If you have near peers who have already appreciated this connection, having them say, it is going to be way more effective than having me say the exact same words and they will often actually bring in little stories from their clinical experience.

As you know, clerks on the ward and those experience will resonate highly with students that are about to go off into their principal clinical experience. They're, you know, all ears for that information. Whereas if I said it, I think they probably half of them be falling asleep. Yeah. Another 1, though, is faculty openness.

To this, and here's where we've had a very interesting time doing grand rounds in various different departments across our system. At Harvard, we, we have sort of the, uh, the beauty and the curse of having multiple clinical affiliates all over the place with multiple departments in each 1, and so we have lots of opportunities to do brand rounds, which helps us hone our ability to hopefully do them reasonably well, but also encounter lots of different groups, and I think in walking through the different disciplines. What I've learned is that the most procedural ones that tend to have the longest training, the most unforgiving hours a culture, which is [00:27:00] the least trauma informed and a trajectory in which people have experienced probably more cumulative medical education and medical practice trauma.

These are the faculty who initially have the least openness to these concepts. However, when you start sharing the stories, what, what ends up shifting from, well, we had to do it this way, and this is the way, you know, you, you build a strong backbone and our trainees need to do the same thing to, you see a shift where people are suddenly in pain and they are now getting a little of the trauma burden that they themselves have carried, and it's quite apparent that that support is needed. They are not just in teaching skills for teaching, but providing resources for what bubbles up for these faculty members as they start to learn more. So, that's been really [00:28:00] very interesting.

Another barrier is simply curricular time. That always is a barrier. And then probably, you know, the biggest thing is the arcaneness of the entire health care system, which so ironically and tragically is not trauma informed and people are trying to address this now, but, but it is hard and hopefully as we're educating more of our medical students who are going out into practice, they will be able to bring fresh eyes and solutions to the fore to help us transform the system to make it better.

Kate Mulligan: He's hoping it's perhaps a not fair burden to put on them, but certainly working from, you know, lower levels up is one way to one way to try and make it happen. So thank you.

Jennifer Potter: I like to think that, we tell our students that that everyone can be a leader within an organization. And we, we really try to unpack what what being a [00:29:00] leader means it doesn't necessarily mean you have to be the CEO. It might mean that on your little team, you can be a catalyst to start something happening, which is different. And so we try to empower students in that way. And even a student can make a big difference if they have that that mindset.

Kate Mulligan: That's a lovely thought and I'm glad that you're giving voice to that. And I hope that we can encourage our students to do the same. It's seems like that would be a real win for me as a teacher if I, if I was able to empower a student like that. So thank you.

So, Jennifer, I think, I'd love to hear your thoughts about how you see widespread adoption of the practice of trauma informed education transforming medical education. Like, what would be your greatest hope, if trauma informed education was incorporated into every medical school?

Jennifer Potter: Right, it is a wonderful thing to contemplate, and I think My greatest hope would be that we would then see trauma informed [00:30:00] principles being integrated at at every level. So people would be integrating them within themselves and noticing the things that we were talking about before about when, when 1 is moving outside 1's window and being able to get back into it and knowing the resources for, for achieving more support. These principles can be applied interactionally, obviously, between a trainee and a patient, but also peer to peer peer to staff within all of our health care systems and that that is also really exciting, and then they can be applied systemically to the institution at large. And I guess there are 2 levels to that, 1 would be more of the local organization. So, the clinic, or the hospital environment, or the medical school that 1 is in at the time, and then the greater would be the way that medical education is reviewed and licensed through, the LCME and at the higher level, the A-C-G-M-E and just [00:31:00] changing the standards by which each institution is being judged for how well it's doing, and, uh, being in a process of continuous trauma informed educational quality improvement. So, the ultimate goal here is that if you really succeed in bringing these principles across all of these different levels, you can achieve greater healing, and well being for everyone within the system.

Kate Mulligan: Fabulous, thank you that's a hope that we all have, I think. So thank you for sharing that. Is it possible to anticipate the evolution of a trauma informed medical education philosophy?

Or do you think we've got a really good handle on it? It's just a matter of spreading the good news or the good practices.

Jennifer Potter: I think I see this evolving actually already. I see the applications in trauma informed care at the patient level. I see the uptake within trauma [00:32:00] informed medical education happening at the undergraduate level less.

So, as he added the level, but I think that it will catch on at the CME level. It's it's beginning to happen as well. And then we have to think about that systemic level, too, and I think that's where we have the most work to be done to keep moving it into that area. That's where people have, you know, heels dug in with with really outdated policies and practices and physical environments and all sorts of different things, but you could absolutely take a similar tack to look at all of those and people are starting to suggest it at this point.

Kate Mulligan: Yes, I think one of the things that you're getting at is The importance of not causing more trauma. So yes, we can, we can start doing trauma informed approaches for people who are already carrying trauma, but we, you know, we really need to focus on [00:33:00] being aware of the potential for trauma that we, that we create in our institutions and policies.

Exactly. Yes.

Jennifer, could you help me understand how you might go about evaluating the effectiveness of trauma informed training programs in medical education?

Jennifer Potter: Definitely that that's obviously very important to attend to it's easiest to evaluate students skills in applying a trauma informed approach to patient care, and we've done some work in this area by incorporating trauma informed care items into our OSCE checklist, and we, we actually recently published a paper, on a set of entrustable professional activities for undergraduate med ed to guide additional skills assessments.

So we took a 1st, crack at that. It can be definitely improved upon, but hopefully people will take it up and kind of run with that. I think it's more difficult to evaluate students skills in the emotion regulation arena and the well [00:34:00] being arena. But, but ultimately, if we do apply a trauma informed systems approach, we can do 2 things.

We, we certainly could look at the learners. So we could look at measures of engagement in learning, learning outcomes. Professionalism outcomes and overall self rated student well being measures, but we also could apply or adapt and apply some measure that's looking at the institution to see how trauma informed it has become, you know, what it is at any point in time.

And, uh. There, there have been some measures like that that have been adopted for clinical spaces. I think they could be adapted for a medical education environment as well.

Kate Mulligan: Great, thank you. That's really helpful. To, wrap this up a little bit, I was wondering if you would like to suggest your favorite resources for someone who's brand new to this and sees that it's something that is really [00:35:00] appealing to them and wants to dip their foot into the water.

Jennifer Potter: Definitely, I think one great resource is to go to TC four meed.org, and this is a great link that has a set of competencies for undergraduate medical education in trauma informed care and has resources that include a whole bunch of really seminal publications on the topic. Uh, so you can easily leapfrog from there.

Um, but, but even looking at the competencies, it can give. Teachers ideas for various things they might use to create learning objectives and then curricula around. And then the other suggestion would be to join a learning community that is talking about this and is really bringing together people from different spaces.

So from medical education, but also from education and other spaces, maybe community members who people who have experienced trauma, who are bringing their authentic voices to the 4 and and other groups. And, there's a wonderful group called a pieces connection. P. A. C. E. S. So pieces connection dot com, you'll find amazing resources.

And there's also at that site, a national collaborative on trauma informed health care, education and research, which is great for us folks who want to get involved in collaborative projects.

Kate Mulligan: Thank you, I love that idea of a learning community, because it does feel like there are a lot of resources. I know I'd refer listeners to the Grand Rounds, where you had just oodles and oodles of articles and resources listed on your slides.

And we'll certainly see you there. add some of those to the show notes for this episode. Uh, and thank you so much for spending the time with me. I really, really appreciate all of the work that you're doing and the fact that you're so generous with sharing that information, and sharing your expertise.

And I thank you so much for coming and wish you all the best of luck continuing on this, on this, uh, fantastic path. So thank you.

Well, thank you so much for inviting me. And as you can see, I am indeed passionate about the topic. And it's always a delight to talk with someone else who is feeling it as well.

Thanks, Jennifer.

Amanda Garza: Thanks for tuning into this episode of CLIME Cast. We hope the conversation spark new ideas and deepened your understanding of trauma-informed care. If you'd like to hear more from Dr. Jennifer Potter, don't miss the recording of her CLIME Grand Rounds. It's available on our website and linked in the show notes.