Why mistreatment of medical students is not reported in clinical settings: perspectives of trainees

HABIBEH AHMADIPOUR, REZA VAFADAR

Abstract

Mistreatment of medical students is a major source of stress for them. Studies indicate a high incidence of such mistreatment, especially in clinical settings. In most cases, students who have been mistreated do not report it to the authorities. This study investigated factors related to the failure to report mistreatment. This was a cross-sectional study carried out in Kerman Medical School, Iran. All students in the internship and clerkship stages, as well as residents, were selected through the census method. Experiences of mistreatment and the reasons for not reporting them were evaluated using a questionnaire. The data were analysed with SPSS 19. Ninety-three per cent of the participants experienced mistreatment, but less than half of them reported it. Residents and interns reported emotional and academic mistreatment, respectively, more than other groups. The most common reason for not reporting mistreatment was that the students did not think reporting would accomplish anything. Our study showed that the experience of mistreatment in the clinical setting is common, but the cases reported to the authorities are far fewer than the actual number of cases. Educational systems should make extensive efforts to detect and prevent mistreatment to improve the teaching–learning environment.

Introduction

Mistreatment has been reported in different occupational environments. Studies throughout the world show that the medical profession is no exception (1). In a profession that trains individuals to be kind and compassionate towards patients, it is expected that the same traits would be observed in the educational environment. However, this is not so in the majority of cases (2).

In 1982, Silver stated that while many students are eager and excited at the beginning of medical training, they become pessimistic, depressed or frustrated over time. He found that this may be due to the fact that they have to bear unnecessary and avoidable mistreatment. He called this phenomenon "medical student abuse"(3). Among the countries from which the abuse of medical students has been reported to occur often are the USA, Pakistan, Finland, Spain and Australia. The prevalence of the mistreatment of medical students varies from 74% to 98% (2).

Authors: **Kerman University of Medical Sciences**, Kerman, IRAN – Habibeh Ahmadipour (corresponding author – ahmadipour@kmu.ac.ir), Assistant Professor; **Research Centres for Social Determinants of Health**; Reza Vafadar (reza.vafadar2000@gmail.com) – General Practitioner, School of Medicine.

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Rautio showed that medical students experience each form of mistreatment more than other students (4). Some teachers feel that mistreatment is an inevitable part of medical education (5). It seems that mistreatment of medical students is common in clinical settings. This is because of the relatively greater interaction between professors and students at this stage and also, the use of teaching techniques involving small groups that are necessary for clinical training. Among the clinical wards, mistreatment is more common in the surgical ward. This is thought to be due to male dominance and power-driven authority (2). Several studies have shown that a large percentage of medical students who experience mistreatment suffer from psychological consequences (4–6). Mistreatment can also have adverse effects on a person's health and performance (3,7-9). In a study, students reported inadequate communication with the perpetrators, low self-esteem and depression as the most common effects of experiencing mistreatment (2). Mistreatment in the clinical environment causes emotional stress in students who are, as it is, under pressure physically and psychologically due to the large volume of pre-clinical curriculum work (10). Schuchert showed that verbal mistreatment affects medical students' confidence as regards clinical procedures regardless of race, age, gender, abilities and public confidence (11). Despite the high prevalence of medical student abuse, the number of cases reported to the relevant authorities is smaller than the actual number of cases (3,12).

There are limited studies on this issue in Iran. Given that previous studies have shown a high prevalence of mistreatment in the clinical environment and that students who have had this experience do not report it to the authorities, this study aimed to investigate the factors related to the failure to report mistreatment from the viewpoint of trainees.

Methods

This study was a cross-sectional one, carried out between April and September 2013 in Kerman University of Medical Sciences (KUMS), located in the province of Kerman in south-eastern Iran. Medical students in the clerkship and internship stages, as well as medical residents who were studying in Kerman University of Medical Sciences during 2013 were selected through the census method. The data were collected using a two-section self-administered questionnaire. The first section contained demographic data, such as age, gender, marital status, duration of study and educational level (internship, clerkship, and residency). The second part consisted of a questionnaire which had been used in a similar study in Japan (3).

Table 1
The frequency of reporting of mistreatment to relevant authorities according to gender, marital status and educational level

		Mistreatment Type							
		Verbal and Emotional		**Physical**		**Academic**		**Gender Discrimination**	
Frequency of experience		140 (89.2)		30 (19.2)		115 (73.2)		87 (56.5)	
Reporting of mistreatment		No	Yes	No	Yes	No	Yes	No	Yes
Marital status	Single	83 (81.4)	19 (18.64)	11 (55.0)	9 (45.0)	78 (92.9)	6 (7.1)	65 (94.2)	4 (5.8)
	Married	29 (76.3)	9 (23.7)	6 (60.0)	4 (40.0)	28 (90.3)	3 (9.7)	19 (95.0)	1 (5.0)
P value		0.5		0.79		0.64		0.89	
Gender	Male	64 (81.0)	15 (19.0)	12 (63.2)	7 (36.8)	62 (94.0)	4 (6.0)	57 (96.6)	2 (3.4)
	Female	48 (78.7)	13 (21.3)	5 (45.5)	6 (54.5)	44 (90.0)	5 (10.0)	27 (90.0)	3 (10.0)
P value		0.73		0.34		0.40		0.33	
Educational Qualifications	Clerkship	61 (88.4)	8 (11.6)	8 (88.9)	1 (11.1)	60 (100.0)	0 (0)	48 (94.1)	3 (5.9)
	Internship	33 (80.5)	8 (19.5)	4 (40.0)	6 (60.0)	29 (87.9)	4 (12.1)	26 (96.3)	1 (3.7)
	Residency	18 (60.0)	12 (40.0)	5 (45.5)	6 (54.5)	17 (77.3)	5 (22.7)	10 (90.9)	1 (9.1)
P value		0.005*		0.06		0.002*		0.8	

**Significant level at PV<0.05*
Participants could select more than one type of mistreatment.

The questionnaire was translated into Persian and back translated for validity. It was adapted culturally and to the current clinical training system. The validity of the questionnaire was confirmed by the panel of experts. Its reliability was determined in a pilot study using Alfa Cronbach 0.67. Mistreatment was categorised into four types: (i) verbal and emotional (shouting, humiliating, insulting); (ii) physical (inflicting physical injury or threatening to inflict it); (iii) academic (being assigned tasks as punishment, being threatened with an unjustly bad score or failure); and gender discrimination (being assigned tasks or being evaluated on the basis of gender). The experience of each type of abusive behaviour as well as whether it was reported to the relevant authorities was recorded. The participants could select more than one type of mistreatment and more than one reason for not reporting it. The study, including the questionnaire, was approved by the research review and medical ethics board at Kerman University of Medical Sciences. The data were analysed using SPSS version 19. The frequency distributions of the responses were calculated and compared using the two-tailed Fisher's exact test or the chi square statistic.

The questionnaires were distributed and collected before or after the scheduled training programmes. The questionnaires were completed anonymously and voluntarily. It took 15 minutes for the trainees to complete the questionnaire.The trainees were assured that the data would be used only for research purposes.

Results

A total of 168 questionnaires were completed (response rate 75%). Ninety-one (54%) participants were male and 124 (74%) single. Eighty-seven (52%) were in the clerkship, 45 (27%) in the internship and 36 (21%) in the residency stage. One hundred and fifty-six (93%) participants stated that during the current clinical stage, they had faced behaviours that they found annoying. One hundred and forty (89.2%) stated that they had

Table 2
The frequency of participants' reasons for refusing to report mistreatment

Reasons*		**Num (%)**
1	When this experience occurred, thought it is not offensive behaviour	9 (7.75)
2	Thought it is not such a significant problem as to be reported to the authorities	16 (13.79)
3	Thought reporting mistreatment would not accomplish anything	41 (35.34)
4	Thought reporting abusive behaviour by a medical student would cause trouble	14 (12.06)
5	I dealt with it directly myself	12 (10.34)
6	I did not know to whom it should be reported	25 (21.55)
7	Was scared that reporting mistreatment would strongly influence my evaluation	12 (10.34)
8	The annoying behaviour did not persist	17 (14.65)
9	Was afraid that reporting would not be kept confidential	12 (10.34)
10	Did not think the problem would be dealt with fairly	20 (17.24)
11	Did not want to be labelled	9 (7.75)
12	Was afraid that they would not believe me	3 (2.58)
13	Was concerned about being blamed	6 (5.17)
14	Did not want to think further about the abusive experience	8 (6.89)
15	Was afraid my professional career would be negatively affected in the future	4 (3.44)
16	Because of the annoying behaviour, I was disappointed with the current situation of education in the clinical setting	15 (12.93)

** Participants could select more than one reason.*

experienced verbal and emotional mistreatment. While most participants said they had experienced abusive behaviour, 112 (80%) cases had not been reported.

A total of 115 (73.2%) participants said they had experienced academic abuse. Of these, 106 (92.2%) cases had not been reported. Of the 87 (56.5%) participants who experienced gender discrimination, only 3 (3.5%) reported the abuse. Physical abuse had been experienced by 30 (19.2%) participants, 17 (56.6%) of whom had not reported the problem. Table 1 compares the frequency of reporting of different types of mistreatment according to gender, marital status and educational level. There was no statistically significant difference according to gender and marital status. The residents reported verbal and emotional mistreatment more than other groups (p=0.005), while the interns reported physical mistreatment more than other groups (p=0.002). The average age of those reporting verbal (p=0.04) and academic (p=0.001) mistreatmentwas significantly higher than that of the others. Table 2 shows the frequency of reasons for refusing to report mistreatment. The most common reason was that they thought reporting would not accomplish anything.

Discussion

This study investigated the factors related to the failure to report annoying behaviours and mistreatment in clinical settings from the viewpoint of trainees. The results showed a high frequency of mistreatment in our clinical settings. Although the effects of mistreatment are mainly emotional, it may affect the students' performance. Despite the high frequency of these experiences, less than half of physical mistreatment, 20% of verbal–emotional and less than 10% of gender discrimination-related and academic mistreatment were reported to the authorities. Similar studies have also shown under-reporting of such behaviours to the relevant authorities. Margittai and colleagues revealed that only a third of the students who had experienced abusive behaviour reported it to the authorities (12). Another study showed that only 31% of students reported experiences of annoying behaviours to someone else (9).

It appears that under-reporting of mistreatment is due to fear of retaliation by the perpetrators and the consequences of this (12). Verbal and emotional mistreatment was reported more often than the other types of mistreatment. This might be because such mistreatment evoked a stronger emotional reaction, which impelled the trainees to report it. The residents reported emotional and academic mistreatment more frequently than the other groups. Perhaps they were more familiar with the clinical setting and had greater experience with the process of reporting. We found no significant difference in the reporting of annoying behaviours between male and female, single and married respondents. According to the participants' statements, the most common reason for refusing to report mistreatment was that it would not accomplish anything. This reflects the negative attitude of students towards the educational system and their lack of faith in its ability to prevent and eliminate these behaviours. Elniki and colleagues found that students do not report mistreatment due to fear of retaliation and the attitude that reporting is not worth it (9). A study by Nagata-Kobayashi found that the most common reason for failing to report mistreatment was that the students did not realise mistreatment was serious enough to be reported to the authorities (3). Cultural differences can result in different reactions to annoying behaviours. Ailee Moon found that cultural factors may affect the risk of mistreatment and problem-solving approaches among different ethnic groups (13). According to a similar study, the definition of mistreatment varies on the basis of gender and ethnicity (14).

Another factor that our participants mentioned as a common reason for failing to report mistreatment was that they did not know how to report. In a similar study in Japan, only 9% of students failed to report due to a lack of knowledge about the reporting process. It is necessary that educational systems prepare medical students for clinical settings. Courses in communication skills may be helpful. In addition, it should be made clear to a student how to deal with inappropriate behaviour from anyone. It is also worth mentioning that the moral character of students influences the decision to report or not report mistreatment. Students with a very rigid moral conscience (superego) can exaggerate the problem, while those who have a poor moral conscience may be less likely to report it (12).

Mistreatment of medical students in clinical settings is a common systemic problem, the eradication of which requires coordinated and multi-faceted attempts (12). The educational system should prevent mistreatment, consider the students' rights and convert discouraging learning environments into supportive learning settings (15). Most medical students consider their teachers as role models for their future professional path. The experience of annoying behaviours may induce negative attitudes towards the medical profession in their minds (7).

Previous studies revealed that behaviours in educational settings have a significant impact on students' mental health. Students who are mistreated are more likely than others to be stressed, experience depression, fear and anxiety, wish to drop out of school and even commit suicide. This gives rise to negative attitudes towards the institution and the care of patients (14,16). In addition, it is common for mistreated students to have a low level of satisfaction with their career and a negative opinion of their profession (14).

Furthermore, medical students who have experienced mistreatment are likely to become teachers who mistreat their students in the future. Kassebaum brilliantly characterises this phenomenon as a "transgenerational legacy that enters them into a culture of abuse. It becomes part of a hidden curriculum which is considered as a barrier for interpersonal communication in the teaching–learning environment, and negatively influences patient care" (14).

Conclusion

According to our study and similar studies in this field, it is common for medical students in the clinical setting to experience annoying behaviours, but most of these are not reported. Whether the reason is fear of the consequences, the moral character of the students, lack of awareness of the reporting process or negative attitudes towards the system, the educational system should undertake extensive efforts to detect, correct and prevent these behaviours to improve the teaching–learning environment.

Limitations

Data collection was based on self-reporting by the trainees; it seems not to have provided precise evidence. Individuals' reactions to a behaviour may be completely different. What is annoying behaviour to one person may be seen as normal by someone else. Another factor to be remembered is that with the passage of time, they may have forgotten their actual reaction to being subjected to mistreatment. One more limitation is that the socio-economic aspect has not been addressed as a predictor variable.

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Conflict of interest

The authors report no conflict of interest.

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