Mistreatment of Students and Residents: Why Can't We Just Be Nice?

It happened again the other day. I was meeting with residents to discuss professionalism, a topic that I have presented to numerous resident groups over the years at various institutions. I have learned that I have about 10 minutes to hook my audience or I will rapidly watch eyes close and heads sway as the built-up fatigue of 80-hour workweeks overcomes the concern of being caught drowsing, and I will be left talking to myself.

In an effort to make the topic authentic and meaningful and to engage my listeners, I usually ask them to share examples of unprofessional behavior that they have witnessed. This invitation can lead in unexpected directions, sometimes to descriptions of mistreatment of residents or students. And that was what happened on this day. A resident with long black hair and a moustache glared at me: "I have a case to discuss," he declared. And I knew immediately that I was in for a bumpy ride. He went on to describe an interaction that he had experienced with a faculty member serving as an attending—it made me cringe. It had started with seemingly innocent questions by the attending. "You said the blood pressure was what? And you did what? And you rechecked it when?" And before the resident could answer, the attending was berating him, demeaning him, humiliating him. The criticism seemed to have come out of nowhere, and the resident felt that he could do nothing correctly after that. Everything he did, the attending second-guessed, criticized, and then used the resident's answers as further examples of how stupid he was. I watched as the resident's face became red as he related the story.

Before he could finish, another resident asked, "Was that Dr. X?"

"Yeah, you got it," said the first resident.

"Oh, don't take it personal, he's reamed me out even worse than that."

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Soon all of the residents were sharing their stories about Dr. X. I no longer was worried about them falling asleep during the lecture. Finally, I said, "This is terrible. Have you discussed this with your program director or your chair?"

"Yeah," a resident responded, "they said they couldn't do anything about it. They said this guy does a lot of cases and we can't afford to lose him. Could you do something about it?"

I thought about his request. What could I do? With the residents' permission, I agreed to pursue the issue and get back to them. Later I met with the program director and the chair of the department, and as I related the story to them, it was as if I had dropped a dead rodent on the floor. They paid attention but did not want to touch it. Eventually they confirmed what the residents had said. The faculty member had his personality "challenges" but provided good care, was a brilliant researcher, and was working on his issues. He had been consulting with a therapist to control his outbursts, and everyone was hoping the incidents I had heard about were a thing of the past.

When I returned to the residents to tell them these responses, the resident who had related the story gave me a wry smile, stared away at the wall for a moment, and then thanked me for at least trying. "Actually, I didn't think you'd come back," he said. As I walked back to my office, I felt that I had let this resident and his colleagues down. I decided to find out what guidance I could glean from the published literature on resident and student mistreatment—and articles in this issue of *Academic Medicine*—to help me come up with a better resolution to future instances of this problem.

I found an early article by Silver[1] that brought the issue of student mistreatment to the attention of the medical community in 1982. Since then, there have been numerous commentaries and studies attempting to clarify the prevalence of student mistreatment, provide a definition, and suggest what could be done to prevent it.[2–6] In its Medical School Graduation Questionnaire (GQ), the Association of American Medical Colleges (AAMC) has surveyed medical students about mistreatment since 1991, and in this issue of *Academic Medicine*, Mavis et al[6] report data from the GQ. They state that from 2000 to 2011, between 12% and 20% of students reported mistreatment. But public humiliation—which is considered by some as a form of mistreatment—has been more common and was reported by 34% of students in the 2012 GQ. In 2001, a definition of *mistreatment* was added to the GQ to guide respondents; Mavis et al report that in 2011 it was updated as follows:

> Mistreatment, either intentional or unintentional, occurs when behavior shows disrespect for the dignity of others and unreasonably interferes with the learning process. Examples of mistreatment include sexual harassment; discrimination or harassment based on race, religion, ethnicity, gender, or sexual orientation; humiliation; psychological or physical punishment; and the use of grading and other forms of assessment in a punitive manner.

Three other articles in this issue of *Academic Medicine* discuss abuse of students and residents. Oser et al[7] add the influence of specialty choice as a cause of mistreatment. They suggest that faculty and residents are biased against certain specialties that differ from their own and may embarrass or criticize students who express interest in those specialty areas.

Fnais et al,[8] in a systematic review of the literature on mistreatment published before July 2011, demonstrate that prevalence rates in the literature averaged 59% for students and 63% for residents. These are far higher rates than the GQ rates reported by Mavis et al, suggesting that how one asks the question about mistreatment is important and that this phenomenon is quite widespread. The sources of the mistreatment were most commonly consultant faculty, patients and their families, fellow residents, and nurses.

Cook et al,[9] in a study of 564 medical students at 24 U.S. schools, noted that 64% reported at least one incident of mistreatment by faculty, and 76% reported at least one incident of mistreatment by residents. The authors demonstrate the potential serious effects that mistreatment has on students, noting an association with burnout.

And in last month's issue of the journal, Gan and Snell,[10] in a recent qualitative analysis of mistreatment using six focus groups of medical students, identified the interaction of a suboptimal learning environment and specific incidents of mistreatment. The authors tried to understand how students described and recognized mistreatment in such an environment. The suboptimal learning environment—which included fatigue, noneducational work activities, and lack of respect—was more pervasive than specific incidents of overt mistreatment; it had an effect on the students' feelings of self-worth but did not rise to the level of reportable mistreatment. The authors expressed concern that mistreatment continued to be common in spite of 10 years of efforts to address it at the institution.

Fried et al[11] similarly reported efforts, such as student and faculty lectures and training, made over a 12-year period (1996–2008) to reduce mistreatment at their institution. They, too, concluded that these efforts did not appear to change the prevalence of mistreatment. They suggested that more targeted interventions aimed at identified individuals might augment institution-wide programs.

Thus the literature describes a persistently high prevalence of mistreatment, and two of the studies mentioned above demonstrate that even long-term efforts to reduce mistreatment have not done so. This suggests to me that the problem is part of the fabric of our institutional environments and will require innovative thinking for its solution. I propose three perspectives that might help us look at this problem in new ways.

The first perspective is from the injury prevention literature. William Haddon,[12] an injury epidemiologist, suggested that injury could be analyzed by breaking up the problem into factors associated with the individual who is injured, the agent that causes the injury, and the environment in which the injury occurs. This model has been applied to a variety of injury problems such as alcohol-related motor vehicle crashes, bicycle crashes, suicide, homicide, and fires. Each injury problem has provided different opportunities for intervention—such as seat belts, helmets, traffic laws, and police surveillance—but the key was to change our thinking from regarding injuries as accidents that occur randomly and without pattern to seeing injuries as events that can be analyzed and prevented.

I believe we can do the same with student and resident mistreatment. If we could think of every incident of mistreatment as possibly predictable and potentially preventable, we might then focus on the tools to accomplish our goals. If, on the other hand, we consider the problem to be erratic, unpredictable, and part of human nature, we will not have the confidence to eradicate it.

Many of the tools we need already exist. We have surveillance systems through the annual surveys of students and residents by the AAMC and the Accreditation Council for Graduate Medical Education (ACGME), as well as the new ACGME Clinical Learning Environment Review visits, and we have the threat of punishment through the Liaison Committee on Medical Education and the ACGME. We need to identify promising interventions at each of the levels—student, faculty, and educational environment—and provide the resources for their adoption, share our successes with our colleagues, and then encourage the enforcement bodies to continue to respond to violations of our standards. Like the problem of alcohol-related injuries, we would differentiate between isolated lapses and those that signify a chronic problem and design interventions accordingly. We would need to carefully look at our learning environment and what we could do to make it more supportive.

The importance of focusing on the learning environment leads to a potentially useful second perspective. Jarvis-Selinger et al[13] described the progression of medical students through stages as they develop their identities. Students are constantly entering new social groupings, where they attempt to become accepted members of a team. I believe that, for a variety of reasons, students do not always succeed in gaining entry to the team and exist on its margins. I think this is true because they do not contribute substantially to the completion of the team's work assignments, may add to the burdens of the team, and are only temporary members of it; they are not given the general umbrella of protection that most teams accord their members. The team may not have any stake in their success. We need to better understand the dynamics at work in the transitions of students and residents between social groupings during their medical educations. How do medical education teams foster or prevent mistreatment? Can we construct healthier teams that provide support for all of our learners? I believe that defining the roles of students in ways that identify their value and their contributions to the team could help in reducing the disparaging comments that students identify as the bulk of mistreatment they receive.[6,8]

A third perspective is offered by a recent innovation in student learning, the longitudinal clerkship experience.[14] Such experiences may be able to help mitigate the constant transition of students in and out of groups by providing a more stable, consistent home base as well as an advocate in their preceptor. A longitudinal clerkship might help reduce fragmentation and increase connectedness between students and faculty preceptors and could foster bonds that would be protective against mistreatment. There may be other ways to help strengthen the role of students and residents as they progress through their training.

I believe that, taken together, the concepts of injury prevention, professional identity formation, and longitudinal learning may be able to provide an antidote to the problem of student mistreatment that has up to now resisted our efforts. Like all of you, I become very frustrated when I hear of cases like the one I presented earlier. I want to hearken back to the words my mother would often say after an incident of my bad behavior at home or school: "Can't you just be nice?" But it is obviously not that simple. Some people, like the faculty member I described earlier, cannot or will not "be nice," and it is our responsibility to identify such individuals and either get them to change or remove them from

the learning environment. At the same time, we need to better understand the way in which learners move through medical education and create routes of safe passage for them, with supportive mentors who know and care about their progress and well-being. Although change in the area of student mistreatment has been too slow, we can be grateful to the education researchers who continue to shine a light on this dark corner of education and give us clues to solutions that will work.

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Editor's Note: The opinions expressed in this editorial do not necessarily reflect the opinions of the AAMC or its members.

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