Strategies to recognize and mitigate mistreatment of medical students

Jonnae Atkinson[1], Lizzeth Alarcon[2], Emilio Blair[3], David Chartash[4], Chantel Clark[5], Amy Clithero-Eridon[6], Adrian George[7], Shira Goldstein[8], Joseph Luzarraga[9], Rebecca Cantone[10]

[1]MD, Department of Family and Community Medicine, Baylor College of Medicine, Houston, United States
[2]MD, Department of Medical Education, Florida International University Herbert Wertheim College of Medicine, Miami, United States
[3]BA, Florida International University Herbert Wertheim College of Medicine, Miami, United States
[4]PhD, Yale University School of Medicine, Section of Biomedical Informatics and Data Science, New Haven, United States
[5]BS, University of New Mexico School of Medicine, Albuquerque, United States
[6]PhD, MBA, University of New Mexico School of Medicine, Department of Family and Community Medicine, Albuquerque, United States
[7]MS, University of New Mexico School of Medicine, Albuquerque, United States
[8]MD, University of Texas Health Sciences at Houston. Department of Family and Community Medicine, Houston, United States
[9]BA, Florida International University Herbert Wertheim College of Medicine, Miami, United States
[10]MD, Oregon Health and Science University School of Medicine, Portland, United States

Abstract

Mistreatment of learners in medical education is a significant problem affecting more than half of all trainees worldwide. This mistreatment can lead to severe consequences, including burnout, post-traumatic stress disorder symptoms, substance misuse, and decreased self-esteem, impacting not only future physicians but also the broader educational community. Despite increased awareness of such harms associated with mistreating medical learners, these behaviors have continued to persist over the years. We aim to equip medical educators and learners with practical strategies to recognize and mitigate mistreatment in the educational setting. We offer examples and concrete advice to help educators and institutional leaders classify mistreatment, navigate various scenarios, and create optimal reporting structures. Additionally, we provide recommendations for dismantling toxic environments and enhancing reporting transparency to build learner trust. Addressing mistreatment will require multifaceted collaboration between learners, educators, and institutions. This advice will help foster a shared commitment to establishing a culture of respect and support among all in the medical learning environment.

Keywords: medical students, medical students mistreatment, mistreatment medical education, medical education educational environment

INTRODUCTION

A comprehensive view of medical education from the perspectives of educators, anthropologists, and trainees reveals that professional identity formation and clinical training are often overshadowed by a facade of mistreatment.[1,2] As physicians training the next generation, it is crucial to avoid perpetuating cycles of mistreatment or harmful student learning experiences in pursuit of our goal of training the most competent physicians.

This article offers practical advice for medical school educators, leaders, and other health professionals to recognize, address, and dismantle mistreatment in educational settings. We also provide strategies to improve reporting and foster a healthy learning environment. Key advice is bolded, and scenarios are italicized to illustrate situations experienced by our student authors.

Classify the Mistreatment Type

The first step in addressing mistreatment is to classify the type. Is the occurrence discrimination, harassment, or general mistreatment? Each of these issues can be investigated at the institutional level. However, discrimination and harassment may have legal protections and implications at a higher level.

On inpatient rounds during a family medicine sub-internship, a third-year medical student is assigned a patient who presents to the ED with acute pancreatitis. The student prepares to admit the patient to the floor with a resident on the team. The student makes errors when attempting to calculate the rate of IV fluids. The resident smiles and says, "I would have expected someone like you to be good at math."

This scenario could be mistreatment or discrimination, depending on the context. To begin, review definitions of mistreatment relevant to your context. In the U.S., The AAMC defines mistreatment as, *"intentional or unintentional behavior that disrespects the dignity of others and unreasonably interferes with the learning process."[3]* Reference your institutional code of conduct for guidance. Mistreatment should be assessed if the behavior *unreasonably* interfered with the learning process. To help make this judgment, ask the reporter to share how they would classify the event.

Address Toxic Environments that Allow for Mistreatment
Worldwide, more than half of all medical trainees experience mistreatment and harassment.[4] Mistreatment in medical students can lead to burnout, post-traumatic stress disorder symptoms, substance misuse, and decreased self-esteem. This issue extends beyond future physicians.[5,6] Therefore, advocating for safe learning environments for all medical learners is essential. Beyond the direct harm to students, a learning environment filled with mistreatment can degrade the quality of education, affecting instruction, assessment, and overall learning.

The family medicine inpatient team student is admitting a patient with chest pain. After presenting to the team, the plan is to consult cardiology. The student calls the cardiology fellow to discuss the consult. When the student cannot answer a question posed by the cardiology fellow, the fellow becomes upset and says on the phone, "You clearly have not read this patient's chart, and you do not know this patient. Tell your resident to call me to discuss this consult" and hangs up. The resident is seeing another patient, and only the attending is around.

Encourage reporting in a safe environment to address individual incidents and to empower

students to dismantle toxic environments in their future workplaces. In order of severity, a step-wise approach to addressing mistreatment begins with providing direct feedback to the perpetrator. Inform them of the allegations, solicit their viewpoints, review policies if warranted, provide constructive criticism, and create an individual improvement plan. If an entire cohort has engaged in inappropriate behavior, conduct a group feedback and teaching session.
.
If the transgression is severe or there is a pattern of poor behavior, it may be necessary to separate the parties involved by removing the teacher from the learner, or vice versa. The most extreme response involves escalating the issue to human resources to place the transgressor on administrative leave or to terminate employment. It is important to set realistic expectations for potential outcomes for both parties. Consequences should be fair and consistent, and a step-wise approach should be used to resolve the issue. Keep the outcome confidential to avoid exacerbating psychological harm to the person who reported the incident. The resolution of the incident should not be constructed solely by either party. Instead, a consensus-driven conclusion should be reached as part of a comprehensive process.

Recognize Public Embarrassment as a Form of Mistreatment
A team finishes long rounds and wants coffee together before the next admission. They ask the student to pick up the coffee because everyone else on the team has 'real responsibilities.'
Minimizing a student's role on the healthcare team interferes with their education, causing them to question their place in the profession. Imposter syndrome, a relatively well-recognized phenomenon, occurs when highly successful individuals attribute their success to external factors, such as luck or knowing the right people.[7] These feelings can lead to a decrease in self-confidence and may escalate to substance abuse, depression, and suicidal ideation.[8,9]

Recognize that Students Experience Mistreatment by Patients
A third-year medical student sees an ambulatory family medicine patient individually, and the patient comments, "I don't want to talk to you. I don't trust medical students, especially students who look like you." The student then tells the faculty, and the faculty sees the patient

independently without debriefing with the student or discussing more with the patient.

Mistreatment of healthcare professionals by patients is a notable problem. Students may be at increased risk for mistreatment by patients because of their training status and exposure to patients in various clinical settings. Fnais et al. examined harassment and discrimination in medical training in studies performed in multiple countries.[6] They found discrimination was most prevalent based on gender, ethnicity, and race. Additionally, they found that patients and their families constitute the second most common source of harassment and discrimination toward medical trainees.[6]

Despite awareness of reporting processes for mistreatment, students often refrain from reporting due to practical or ethical concerns.[10] Students wonder whether reporting will significantly change patient behavior or impact their grades.[10] Data suggest that trainees who experience mistreatment report increased anxiety, avoidance of specific patient types, and, in some cases, reconsideration of their career choices or practice locations.[11]

To effectively address the mistreatment by patients towards healthcare trainees, it is crucial to implement policies that specifically address such incidents and provide guidelines for handling patient accommodation requests. Equally important is the training of faculty and staff to support and debrief students who encounter mistreatment from patients.[12–14] Integrating mixed curricula featuring case-based scenarios, often in video format, can educate faculty, staff, and trainees on recognizing and responding to mistreatment.[12,15] Workshops structured for discussion and role-playing offer practical, real-time experience managing mistreatment incidents.[12] Faculty development may also emphasize appropriate patient screening practices to prevent placing students in challenging situations without adequate support.[10]

Recognize the Effect of Reporting on Faculty
Assuming the majority, if not all, medical educators approach their teaching responsibilities with good intent and enthusiasm, it can be surprising, demoralizing, and anxiety-inducing for an educator to learn they are the subject of a student mistreatment report. Once a medical educator is notified about their involvement in a report, several steps can be taken to facilitate a positive outcome. Initially, scheduling a prompt meeting can address immediate faculty concerns, alleviate anxiety, and assess the educator's emotional state. The meeting

can also define outcome goals and structure ongoing communication to monitor progress toward achieving goals. Pairing the educator with a colleague in the department for regular check-ins can provide additional support and mentorship to enhance the probability of a successful outcome. Recognizing and affirming the faculty's commitment to becoming a better educator upon achievement of their goals is essential. It is important for medical educators to understand that how they respond to student mistreatment and complaints can underscore their ability to accept constructive feedback, effectively handle criticism, and demonstrate a growth mindset, all qualities valued in successful teachers, and learners.

Value the Role of the Graduate Medical Learner
Postgraduate trainees (e.g., junior doctors, house officers, interns, registrars, and residents) play a significant role in the education of medical students. They are closer in age to medical students and thus often serve as role models for student behavior. Therefore, training this cohort to become better teachers is crucial to optimizing the student learning experience. For example, properly equipping them with skills such as giving and receiving feedback can significantly enhance the learning environment.

Additionally, as integral members of the educational team and clinical environment, postgraduate learners must understand the processes for reporting mistreatment and discrimination at their institution, and their responsibilities as witnesses or involved parties. Ensuring that postgraduate trainees are well-informed and engaged in these processes can positively influence the culture of the learning environment.

Ensure Follow-up is Complete
Ensure a proper procedure is in place for comprehensive follow-up after an incident of mistreatment. A follow-up protocol that concludes the process will help the mistreated party feel heard and ensure their incident was addressed. Put measures in place to protect the mistreated party and the accused from retaliation. The integrity and character of all parties should be safeguarded throughout the reporting process. While reporting may be anonymous, essential details about the incident should be included to ensure a thorough understanding of the situation.

Transparency is also critical. Informing the students of the outcome can empower them to speak up if they experience or witness inappropriate behavior.

Additionally, de-identified and broad reports should be shared with student groups, faculty, and leadership. Reporting can drive cultural change within the profession by validating student experiences and reinforcing that certain behaviors are unacceptable. Without reporting, students may become disengaged and disillusioned and perpetuate negative behaviors.

CONCLUSION

Finally, don't wait for incidents to be reported. Take a proactive approach to prevent student mistreatment. Strategies include creating a positive working environment with uplifting visuals in the workspace, and conducting simulations to train individuals—including bystanders—on proper responses to various mistreatment scenarios. Providing new students, faculty, and staff with an overview of policies related to student mistreatment and reporting can promote a culture of awareness, recognition, and intervention. Creating spaces for critical reflection allows students and faculty to discuss recent challenges, brainstorm helpful strategies, and identify growth areas.

Emphasize building a culture of *solutions* rather than focusing on problems. Training and policies alone are insufficient, without a culture of proactive engagement, to ensure a shared language and understanding of the desired outcomes related to delivering quality medical education in a respectful and safe environment.

References

1. Konner M. What will become of the doctor? Yale Journal of Biology and Medicine. 1996;69: 469–476. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2588997/

2. Kirk LM. Professionalism in medicine: definitions and considerations for teaching. Proc (Baylor Univ Med Cent). 2007;20: 13–16. https://doi.org/10.1080/08998280.2007.11928225

3. Mavis B. Measuring Mistreatment: Honing questions about abuse on the association of American medical colleges graduation questionnaire. AMA Journal of Ethics. 2014;16: 196–199. https://doi.org/10.1001/virtualmentor.2014.16.3.stas1-1403

4. Chung MP, Thang CK, Vermillion M, Fried JM, Uijtdehaage S. Exploring medical students' barriers to reporting mistreatment during clerkships: a qualitative study. Medical Education Online. 2018;23: 1478170. https://doi.org/10.1080/10872981.2018.1478170

5. Cook AF, Arora VM, Rasinski KA, Curlin FA, Yoon JD. The prevalence of medical student mistreatment and its association with burnout. Academic Medicine. 2014;89: 749–754. https://doi.org/10.1097/ACM.0000000000000204

6. Fnais N, Soobiah C, Chen MH, Lillie E, Perrier L, Tashkhandi M, et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. Academic Medicine. 2014;89: 817. https://doi.org/10.1097/ACM.0000000000000200

7. Stephens MB. Behind the mask: identity formation and team building. Annals of Family Medicine. 2019;17: 561–561. https://doi.org/10.1370/afm.2447

8. Gottlieb M, Chung A, Battaglioli N, Sebok-Syer SS, Kalantari A. Impostor syndrome among physicians and physicians in training: A scoping review. Medical Education. 2020;54: 116–124. https://doi.org/10.1111/medu.13956

9. Lusk P, Ark T, Crowe R, Monson V, Altshuler L, Harnik V, et al. Measuring the development of a medical professional identity through medical school. Medical Teacher. 2023;0: 1–7. https://doi.org/10.1080/0142159X.2023.2273218

10. Hu A, MacDonald G, Jain NR, Nimmon L. Exploring mistreatment of medical students by patients: a qualitative study. Academic Medicine. 2023;98: 1164–1172. https://doi.org/10.1097/ACM.0000000000005304

11. Dvir Y, Moniwa E, Crisp-Han H, Levy D, Coverdale JH. Survey of threats and assaults by patients on psychiatry residents. Academic Psychiatry. 2012;36: 39–42. https://doi.org/10.1176/appi.ap.10060090

12. Wilkins KM, Goldenberg MN, Cyrus KD. ERASE-ing Patient mistreatment of trainees: faculty workshop. MedEdPORTAL. 2019;15: 10865. https://doi.org/10.15766/mep_2374-8265.10865

13. Whitgob EE, Blankenburg RL, Bogetz AL. The discriminatory patient and family: strategies to address discrimination towards trainees. Academic Medicine. 2016;91: S64–S69. https://doi.org/10.1097/ACM.0000000000001357

14. Cyrus KD, Angoff NR, Illuzzi JL, Schwartz ML, Wilkins KM. When patients hurt us. Medical Teacher. 2018;40: 1308–1309. https://doi.org/10.1080/0142159X.2018.1428291

15. Mahoney DA, Gopisetty D, Osterberg L, Nudelman MJR, Smith-Coggins R. Patient mistreatment of health care professionals. BMC Medical Education. 2022;22: 133. https://doi.org/10.1186/s12909-022-03198-w