If you can’t make it, you're not tough enough to do medicine’: A qualitative study of Sydney-based medical students’ experiences of bullying and harassment in clinical settings

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Abstract

Background: Media exposés and academic literature reveal high rates of bullying and harassment of medical students, most commonly by consultant physicians and/or surgeons. Recent reports reveal the medical profession to be characterised by hierarchy, with verbal abuse a ‘rite of passage’, as well as sexist and racist behaviours. Methods : Semi-structured in-depth interviews were conducted with ten current or recently graduated medical students from Sydney-based medical schools. Interviews were audio-recorded, transcribed verbatim, and thematically analysed. Results : Hierarchy, and a culture of self-sacrifice, resilience and deference, were identified as problematic elements of the medical profession. In the minds of participants, these factors created barriers to reporting mistreatment, as participants felt reporting led to being labelled a ‘troublemaker’, affecting career progression. Additionally, participants stated that avenues of recourse were unclear and did not guarantee confidentiality or desired outcomes. Conclusions : Mistreatment is continuing in clinical teaching and has negative consequences on medical students’ mental health and learning. Structural change is needed to combat institutionalised mistreatment to ensure the wellbeing of future doctors and high quality patient care.

Background

Hierarchy plays an essential role in all professions. However, hierarchy in medicine today is characterised by an imbalanced relationship between superior and subordinate, rather than a mentoring relationship between teacher and learner (1). While the culture of patient care is changing to incorporate a more patient-centred perspective, (2) the demands of busy, unpredictable clinical workplaces mean that strict power hierarchies continue to govern hospitals, and professional culture is dominated by power imbalance, overworking and subsequent ‘burnout’.

The lingering presumption that mistreatment in this environment is ‘beneficial’ because ‘if you can’t make it, you’re not tough enough to do medicine’ (3) has been challenged by exposés of workplace bullying and harassment. Cases of doctors being bullied out of specialty training programs, hospitals stripped of training accreditation, and declining mental health of medical trainees, are all purportedly products of the exigent culture within medicine (4-8). In the past year alone, Bankstown-Lidcombe, St George, Royal Prince Alfred, Westmead and Tamworth hospitals have all made headlines regarding mistreatment of junior doctors (8-11). The umbrella term ‘mistreatment’ will be used to refer to professional misconduct that occurs in clinical settings, and definitions of bullying, harassment and sexual harassment can be found in *Appendix 1*.(12)

2.1 Rates of Bullying & Harassment in Medicine

In 1990, The Journal of the American Medical Association (JAMA) published a landmark study observing the incidence, severity and significance of abuse of medical students (13). This United States (US)-based study was the first to document the incidence, severity and significance of abuse from medical students’

perspectives, and thus provides important background for our study. The anonymous cross-sectional questionnaire revealed 46.4% of the 519 participants reported being mistreated at some point during medical school, 80.6% of seniors were abused by their senior year, while 49.6% of those abused stated that the most serious episode of abuse would 'always affect them'.

Medical schools and colleges have since instituted anti-harassment policies, grievance committees, 'confidential' complaint avenues and counselling programs (6, 10, 14). Despite such efforts to ameliorate abuse and increase awareness, media exposés of mistreatment in medical training remain frequent.

Academic literature confirms ongoing mistreatment of medical students in medical schools overseas. A 2006 US study, which included 2,316 participants from sixteen US medical schools, reported 85% of students being 'harassed or belittled', 40% experiencing both, and 13% describing an incident as severe (15). A 2014 systematic review and meta-analysis of fifty-seven cross-sectional studies and two cohort studies reported 59.4% of medical trainees, globally, had experienced at least one form of harassment or discrimination (16). Both studies identified verbal harassment as the most common form of mistreatment, and consultants as the most consistent perpetrators. While these data cannot be extrapolated to the Australian context, they are suggestive of an issue within the culture of medicine that might transcend national boundaries.

In Australia, the Australian Medical Association (AMA) confirmed that more than 50% of doctors and trainees (not including medical students) have been bullied or harassed, with verbal harassment and consultants again most commonly cited (17). Overall, the literature reveals consistently high (at least 50%) rates of bullying, harassment and discrimination in medical training (12, 18-22). This incidence is alarmingly high, despite authors noting probable underreporting due to studies being led by faculty members of students' institutions.

2.2 Students' Perceptions of Mistreatment

A 2015 pilot study involving surveys of final stage medical students from two Australian medical schools found that medical students believe mistreatment is institutionalised (22). Participants perceived doctors as having leeway to bully because the medical profession is characterised by a 'different moral order' (22). This protection allows abusive behavior, unacceptable in any other professional environment, towards patients, staff, and students.

One of the difficulties in quantifying the extent of mistreatment of medical students is the diversity of students' perceptions of mistreatment. Surveys asking for specific instances of abuse, such as sexual harassment or racism, narrow participants' perceptions of their own mistreatment and impose preconceived definitions of abuse, which may lead to underreporting. A US-based study found 73% (n=4,530) of nurses reported witnessing disruptive behaviour within their hospital, compared to 48% of physicians (23). The lack of registering mistreatment as problematic within medical professionals likely contributes towards bystander silence, and is therefore a factor that demands further research. This study aims to provide an Australian perspective on this topic.

While there exists substantial literature on the *rates* of bullying and harassment within medical schools, much of the available data lacks students' *perceptions* of mistreatment. This qualitative study captures personal stories, the standard of medical teaching, and how experiences have impacted medical students, which quantitative data fails to represent. Additionally, it systematically analyses this information in a way that media exposés cannot, allowing previously unappreciated patterns to emerge.

2.3 Aims

This study aimed to capture medical students' experiences of bullying, harassment, culture and teaching in clinical settings, as well as the effects of mistreatment on students. Additionally, the study aimed to explore the factors contributing to underreporting; do students fail to recognise behavior as problematic, or do they harbour distrust in the complaint system? The key objective is the provide a rich account of Sydney-based medical students' perceptions of mistreatment in clinical spaces. The study also asked medical students what changes they believe may be effective in increasing accessibility of complaint systems. The findings of this study will help inform future anti-bullying strategies and is anticipated to have a positive effect on clinical teaching.

Methods

3.1 Research Design

Qualitative data were generated through semi-structured in-depth interviews. The interview process allowed appreciation of 'context-specific depth' (24) through open-ended enquiry, and the unpacking of differing perspectives behind behaviours, beliefs and assumptions (25). Furthermore, open-ended discussion promoted stronger completion and formulation of interviewee speech by the researcher (26, 27).

3.2 Participants

Recruitment occurred online via social media. To be eligible, participants were required to satisfy the following criteria (1) aged eighteen years or above; (2) current medical student or recent graduate (within 2 years of graduating); and (3) studying at a Sydney-based medical school.

3.3 Data Collection Methods

Data were collected through semi-structured, in-depth, face-to-face or telephone interviews. Informed consent was obtained prior to commencing each interview, and pseudonyms were used to preserve anonymity. Interview domains can be found in *Appendix 2*. Interviews were audio recorded, transcribed verbatim, de-identified and stored securely at the Kirby Institute, UNSW Sydney.

3.4 Investigator team

All interviews were conducted and transcribed by the first author LC, who is herself a medical student. The benefits of peer interviewers identified in the literature are improved acceptance of disenfranchised groups, improved quality of research, and increased comfort of participants in the research process, while the challenges relate to the training and support of peer researchers.(28) This team also included one experienced qualitative researcher (BH) and an experienced physician/researcher (LC) in supervisory roles minimising the training burden and maximising, the benefits of the peer researcher approach, where rapport and trust were quickly and effectively established with participants.

3.5 Data Analysis

Data were managed, coded and analysed using NVivo software (29). The identification and analysis of themes occurred in a 'bottom-up' manner, in that data was not coded to fit into the pre-existing research question framework. This thematic analysis was conducted using a systematic framework developed by Castro, Kellison (30) adapted from Braun and Clarke (31) (*Figure 1*). There were six steps in the analysis: 1. close reading of interview transcripts; 2. generating initial codes through inductive process; 3. Discussion within the research team of initial coding to identify thematic categories; 4. Review and revise initial thematic categories and coding with respect to the whole data set; 5. Defining themes; 6. Analysis of the themes and selected quotes in relation to the whole data set.

Results

The participant sample comprised ten current or recently graduated medical students (three men and seven women) of metropolitan, rural and international backgrounds (see table 1).

Participants' responses generated six thematic categories for analysis: Hierarchy, culture, avenues of recourse, pressures on medical students, mistreatment from patients and quality of teaching. Together, these thematic categories provide insight into how medical students in this study perceive the structures and cultures of clinical settings collude to enable mistreatment to occur in an environment where speaking out against it is considered likely to have a negative rebound effect on the whistle-blower.

Table 1: Participant Demographics

Participant Pseudonym	Age	Gender	Ethnicity	University	Year of Study	Geographic Origin
Colette	28	Female	Caucasian	University of Sydney	Three	Metro
Alice	21	Female	Caucasian	UNSW	Four	Metro
Theo	21	Male	Caucasian	UNSW	Four	Metro
Sanjna	24	Female	Indian	UNSW	Graduated 2018	Metro
Arosh	24	Male	Sri Lankan	UNSW	Six	International
Peter	21	Male	Caucasian	UNSW	Four	Rural
Abby	23	Female	Caucasian	UNSW	Five	Metro
Lily	23	Female	Caucasian	University of Sydney	Two	Metro
Jarra	22	Female	Caucasian	UNSW	Four	Rural
Lauren	23	Female	Caucasian	University of Sydney	Two	Metro

Discussion

This study provides insight into medical students' experiences of mistreatment, and the impact it has on their wellbeing and clinical learning. Although many participants did not report serious instances of misconduct, they nevertheless identified some of the driving forces perpetuating mistreatment in medical school, as well as other challenges faced by medical students. The findings highlight problematic aspects of medical teaching and culture, and potential avenues for change and future research.

Participants often felt that intergenerational change was not occurring and that anti-bullying strategies have been ineffective because of the cyclical nature of mistreatment. This helps explain why mistreatment is entrenched in medical culture, and where intervention may be necessary. Wood (19) argued that the psychological qualities that allow some students to cope with abuse or ignore unwanted events perpetuate the problem. These students qualify, move into positions of authority within the medical workforce, and encourage the same behaviours and practice of non-reporting, not viewing these issues as problematic within their own training. For example, Australia's Productivity Commission Report found 74% of medical students have been victims of and 86% have witnessed intellectual humiliation (20), in line with participants' experiences and reinforcing their self-described need to be resilient. Scott, Caldwell (22) propose that intellectual humiliation forces students to align their values with those of their superiors, adjusting their professional ethical code in order to survive, and maintaining the dominant

culture of medicine wherein victims become perpetrators. For this reason, more structural change may be needed, such as formal training of supervisors, to protect current medical students and break this cycle.

Several elements of medical culture were discussed by participants as problematic and potential contributors to mistreatment. Self-sacrifice and resilience were identified by most participants as central to being a doctor. This plays into traditional medical paradigms; because of the vulnerability of patients and non-proprietary nature of the medical profession, doctors are bound by moral obligations to be altruistic, even when this compromises their own wellbeing (32). Cohen (33), then President of the Association of American Medical Colleges, described 'commitment to self-sacrifice' as an essential attribute for acceptance into medical school. Major (34) attributed the emphasis on self-sacrifice to structural pressures in the healthcare system that require medical students to 'act as professional and ethical chameleons'. Consequently, in an overburdened hospital, concealing minor errors and unconditionally agreeing with senior doctors are encouraged. Participants in this study, similarly, identified overworking and underreporting as products of self-sacrifice, propagating mistreatment.

Participants described the medical hierarchy as a pervasive feature of medical education and source of toxic workplace culture and underreporting. Similarly, a 2004 British qualitative study yielded the 'hidden curriculum' of medicine (35). This was defined as an informal standard of learning that instills acceptance of hierarchy, compromise of ethical integrity and emotional neutralisation. These agendas may manifest as abuse and intellectual humiliation, leading to the perpetuation of the medical hierarchy at the cost of professionalism.

This study provides clear evidence to support the need for change in medical school and hospital environments. This may involve reforming the medical admission process, greater accessibility of reporting systems and emphasis on self-care, and formal workplace restructuring to prevent overworking, such as more interns allocated to a team.

Understanding how medical students approach reporting mistreatment was a key aim of this study. Many participants cited being labelled as 'sensitive' or a 'troublemaker' as barriers to reporting. The resilience participants identified as being necessary to cope with confronting emotional or physical situations may translate to professional reticence and underreporting, though this requires further research. Participants also lacked confidence in the anonymity of reporting systems and certainty of repercussions for troublesome personalities. These results reinforce Australian studies by the AMA (17) and Scott, Caldwell (22), who found less than one third of victims reported abuse in medical school. They cited fear of reprisal, lack of confidence in the reporting process, fear of impact on career, and cultural minimisation of the problem as reasons medical trainees do not report mistreatment. These findings align with a Canadian study that found, of students who had reported incidents, only 35.9% were satisfied with the outcome (36).

An array of solutions were suggested by participants to address unprofessional behaviour. For example, one participant mentioned the Vanderbilt Coworker Observation Reporting System (CORS) which aims to address disrespectful and unsafe physician behaviour with scaled consequences, escalating from an

‘informal’ cup of coffee intervention to ‘disciplinary’ intervention (37). Piloting a similar framework in Australian medical schools and hospitals could potentially encourage utilisation of reporting systems, guarantee confidentiality, and assure outcomes, all of which were identified by participants as desirable to counter underreporting.

All female participants felt gender played a problematic role in their clinical teaching or future decision-making. They felt medicine was male-centric, in both the quality of teaching women received and curriculum itself. Many female participants stated they had received fewer opportunities, were ignored by male supervisors, or felt uncomfortable because doctors were always referred to as ‘him’ or ‘he’ by physicians. Beyond Blue’s 2013 Australian survey, which included 1,811 respondents, showed that 20% of medical students had contemplated suicide in the last twelve months, but 25% for female medical students (38). However, this is the extent of academic literature regarding Australian female medical students’ experiences and perceptions of mistreatment. Because this was a key issue raised in this study, there is scope for further research into gendered experiences in clinical teaching.

Participants described a toxic workplace culture, including ‘servant’ behaviour and gendered mistreatment, which made participants and their peers feel uncomfortable, unsafe, and unhappy. The practice of ‘pimping’ students – an American term meaning excessive, inappropriate questioning of students and trainees that produces shame and humiliation– was also a stressor for participants. (39) Academic literature has well established that medical students who report mistreatment are more likely to experience lower career satisfaction including questioning their chosen profession, increased likelihood of drop out, substance abuse, anxiety, reduced self-esteem, higher levels of stress, depression and suicidality (15, 19, 36, 40, 41). The literature also suggests that medical students’ experiences may differ by chosen specialty.(15)

Some participants also believed patient outcomes are compromised by overworking and mistreatment, factors like sleep and adequate family time being essential to better mental health and, consequently, quality of patient care. Disruptive workplace behaviour has been shown to have negative impacts on team collaboration and communication efficiency, diminishing staff performance and morale, and contributing to trainees feeling forced to cope with clinical issues beyond their training (17, 23, 42). Similarly, a US staff survey showed that 71% of respondents (doctors and nurses) believed unprofessional behaviour contributed to medical errors, with 27% stating it had contributed to a patient’s premature death (43). This is supported by a 2015 randomised blinded trial showing that medical teams treated ‘rudely by an expert observer’ performed significantly worse in a paediatric emergency simulation (44). Furthermore, higher staff absenteeism due to stress and workplace dissatisfaction impacts continuity of patient care and increases the workload of other staff (43). This study contributes to this body of literature necessitating structural change to address toxic medical culture in order to maximise quality of patient care and student wellbeing.

This study had some limitations. Firstly, the inclusion criteria purposefully sampled people who had experienced or witnessed mistreatment, which may have influenced the study’s results as participants

were more likely to have strong views about mistreatment in clinical settings. Secondly, participants were only eligible if they attended a Sydney-based medical school. However, six of the participants had rural clinical experience, and discrepancies between rural and metropolitan teaching were often raised. There is scope for future research comparing rural and metropolitan teaching and working environments. Finally, as a small qualitative study the results may not be generalisable to a wider population.

Despite these limitations, this study provides a strong qualitative foundation for understanding the challenges faced by medical students, and how these obstacles, such as those preventing incident reporting, can be overcome. More clarity surrounding reporting systems, reinforcing their confidentiality and guaranteeing outcomes are some ways in which medical students may feel safer and more supported in their training. Additionally, providing participants with more structured clinical teaching, including enforcing formal learning objectives and supervisor training, may alleviate the anxiety and inappropriate teaching currently problematic in unorganised clinical teaching.

Furthermore, this study identifies concerns of medical students for which there may be scope for future research. These include inclusion of diversity in teaching, the medical admission process, and ethics and values in the medical curriculum.

Conclusion

Given the persistent nature of these highly problematic behaviours in clinical workplaces (13, 16, 17), understanding how witnessing or experiencing clinical misconduct impacts medical students' learning and wellbeing is important. Mistreatment of medical students has tangible consequences for future doctors, affecting their mental and physical wellbeing, as well as for wider society due to the implications on quality of patient care. This issue is therefore highly relevant. Structural change is needed to remedy the mistreatment institutionalised in medical culture and teaching.

Abbreviations

JAMA	*Journal of the American Medical Association*
US	*United States*
AMA	*Australian Medical Association*

Declarations

10.1 Ethics Approval & Consent to Participate

All participants provided informed consent prior to interviews, either verbally (phone interviews) or written. This project received ethics approval from the UNSW HREC Executive (HC180948, see *Appendix 1*).

10.2 Consent for Publication

All participants provided informed consent to publication. Our ethics approval also specified that we intended to publish in peer-reviewed literature.

10.3 Availability of Data & Materials

As these data are qualitative interviews, raw data will not be made available so as to protect participant confidentiality.

10.4 Competing Interests

LJC is a peer researcher.

10.5 Funding

This project did not receive any specific funding. However, BH and LC receive funding from Australia's National Health and Medical Research Council

10.6 Authors' Contributions

LJC

Contributor	Statement of Contribution
Student Researcher	· Project conception and design · Ethics application · Recruitment · Data collection, analysis and interpretation · Manuscript preparation
BH Supervisor	· Project conception and design · Ethics application · Data interpretation · Critical revision of manuscript
LC Co-Supervisor	· Project design · Data interpretation · Critical revision of manuscript

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Figures

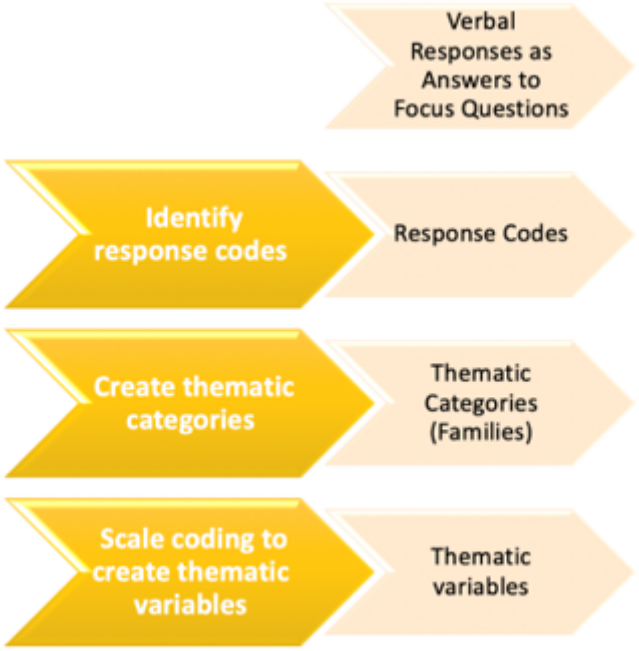

Figure 1

Stages of Thematic Analysis (30)

Supplementary Files

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- appendix.pdf