"Constantly ignored and told to disappear": A review of the literature on "teaching by humiliation" in medicine

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Abstract

Introduction: The aim of this narrative review of the literature was to use systematic search and review procedures to describe a contemporary understanding of the expression "teaching by humiliation."

Method: A search was conducted of MEDLINE, 1990–2013, using search terms humiliat*, intimidat*, harass* and abus*. Three hundred and forty-one papers were located; however, only papers related to medical students and medical trainees were considered. Papers dealing with substance abuse, patient abuse and sexual harassment were excluded. Of the 341 papers located, only 30 met the criteria for inclusion. One reviewer/author read all 30 papers; both reviewers/authors annotated 15 papers each, and subsequently agreed on the following categories for the systematic review: clarifying terminology, identifying specific behaviours, the extent of the problem, explanations posited, and finally, the effects of humiliation and abuse.

Results: The review confirmed that the expression "teaching by humiliation" appears in the literature but that "abuse" and "mistreatment" are more common terms for medical teachers' behaviours towards students. These behaviours range from yelling, shouting and physical abuse to subtle undermining and demeaning language and practices. The behaviours are widespread and persistent across many countries, and victims suffer personal and professional effects.

Conclusion: There is ongoing concern in the literature about the culture of medical education that perpetuates these practices and the failure to interrupt that culture despite decades of research and commentary.

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Introduction

University staff and students are often protected by policies that promote environments free from abuse in the form of harassment, discrimination and bullying (see https://policy.unimelb.edu.au/MPF1230) (University of Melbourne, 2014). Taking a broader view, there is widespread agreement that learning environments need to be free of practices that produce fear and anxiety (Spencer & Lennard, 2005). However, medical teachers are known to refer to intimidating and humiliating practices when discussing their experiences of, and approaches to, teaching (Barrett, 2013; Spencer & Lennard, 2005). These expressions reflect, perhaps, the situation that "[in] the age of professionalism, student harassment is alive and well" (Neville, 2008, p. 447). They also indicate that, in the complex system that is medical education, some teachers are "chronic violators" of the profession's standards (Hafferty & Castellani, 2009, p. 31) and are undermining efforts to promote these standards (Mossop, Dennick, Hammond, & Robbe, 2013).

Medical students' reports of verbal interactions with junior medical staff that contribute to their negative experiences of clinical rotations have recently been discussed (Scott et al., 2014). Over many years of conducting workshops for young doctors, we have heard the phrase "teaching by humiliation" associated with their experiences of teaching and learning. Often, in these discussions, debate ensues about the positive value of such practices. We have concluded that these terms may refer to practices that are not always obvious and sometimes even denied within the medical profession and particularly in teaching hospitals. Subsequently, we have taken the view that "acknowledgement of the existence of this problem would be a good starting point" (Imran, Jawaid, Haider, & Masood, 2010, p. 594). In undertaking the review presented here, we sought to advance a contemporary understanding of "teaching by humiliation."

One of the reasons for concern, related to these reports, is the likely implication for medical professionalism, particularly as that notion is receiving much current attention (Bartle, 2014; Birden et al., 2014; Wynia, Papadakis, Sullivan, & Hafferty, 2014). Our particular concern focuses on the professionalism of medical teachers (current and future) and the connection between teaching practices, the medical culture and the future of the medical teaching workforce.

Method

A narrative review using systematic search and review procedures

This review was conducted using systematic procedures to locate and select relevant literature on the subject of "teaching by humiliation." A search was conducted in MEDLINE via the Web of Knowledge search engine. The MeSH headings "Education, medical" were used to search the topics: humiliat*, intimidat*, harass* and abuse. The search was limited to the period 1990–2013. Three hundred and forty-one papers were

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located, but all but 30 of these dealt with abuse of substances or abuse of people other than students or trainees, that is, they were not relevant to "teaching by humiliation." Of the 30 papers that were considered relevant, only two explicitly used the term "teaching by humiliation"; some used the term "mistreatment," "abuse" or "bullying" to describe the subject. Three types of papers were reviewed: empirical reports, commentaries/editorials and papers related to medical practitioners and/or students. These papers were included because they support the purpose of our review, which was to generate a contemporary understanding of "teaching by humiliation" and related expressions in medical education.

One reviewer read all the papers (JB), and each of the two reviewers annotated half of the papers according to the following headings: author, date, country, type of paper (empirical/review/commentary), definitions, participant groups, findings, conclusions and recommendations. Each reviewer identified categories in their 15 papers, and the two reviewers met to determine one set of categories that captured the main areas addressed and the findings of the studies, as well as the areas of concern in the commentary papers.

Comment on scope and method

Since completing our review, the journal *Academic Medicine* has published a number of papers addressing medical student "mistreatment," including a systematic review and a number of research reports. The systematic review of 51 studies published between 1987 and 2011 sought an understanding of the significance of the problem of "harassment" and "discrimination" of medical students and doctors in training by supervisors and explored preventative strategies (Fnais et al., 2014). Another paper focused on understanding the complexities associated with students' perceptions of mistreatment (Gan & Snell, 2014). Also, a paper by Mavis, Sousa, Lipscomb and Rappley (2014) highlighted that although evidence of medical student mistreatment has accumulated for more than 20 years, it has only recently been officially acknowledged and included in the annual survey of medical graduates in the USA. That paper reviewed national "mistreatment data" (p. 705) from these surveys, including prevalence, types, sources, reporting and ways to address abuse.

Two of the other studies reported in that journal addressed particular factors associated with mistreatment of medical students. One survey-based study found that recurrent mistreatment of medical students is associated with student burnout, without concluding that there is a causal link (Cook, Arora, Rasinski, Curlin, & Yoon, 2014). In another report of a longitudinal survey-based study, the researchers found mistreatment of students based on choice of specialty is common and has particular long-term consequences related to the tolerance of dishonest and disrespectful behaviours (Oser et al., 2014). The editor of the volume in which these papers are published asked, "Why can't we just be nice?" (Sklar, 2014, p. 695). In answering this question, the editor noted that some people actually cannot be nice, but also suggested that more research is needed to continue "to shine a light on this dark corner" of medical education.

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Results

In this paper, we provide a synthesis of the broad concepts that emerged from our review of the literature. The review offers clarification of the term "teaching by humiliation," identifies understandings of "humiliating" and "abusive" teaching practices, explores the extent of the practices and explanations posited, and discusses the reported effects on individuals and institutions. We provide an overview of each of these concepts before returning to a discussion of our concerns related to professionalism.

Clarifying "teaching by humiliation"

The review of the literature revealed that concern about abusive behaviours and practices in medical education are well documented. Over the past 25 years, research has continued to identify a range of behaviours that might be considered abusive and/or humiliating. Early reports identified "subtle undermining of students' abilities and motivation and derogatory remarks and direct verbal attack" and described students' perceptions of teachers' offensive treatment, insulting or unjust ways of speaking to students (Sheehan, Sheehan, White, Leibowitz, & Baldwin, 1990, p. 534). Other authors described abusive behaviour as "unnecessary or avoidable acts or words" (Silver & Glicken, 1990, p.527).

Our starting term, "humiliation," is also explicitly addressed in some research. Lempp and Seale's (2004) seminal qualitative study found teaching that involved humiliation. Others described mistreatment, harassment, public humiliation (Baldwin, Daugherty, & Eckenfels, 1991), contempt, belittlement, humiliation (Rautio, Sunnari, Nuutinen, & Laitala, 2005), disrespect (Karnieli-Miller et al., 2009), bullying (Rees & Monrouxe, 2011), "pimping" (meaning asking questions aggressively) (Anderson, 2013; Zou, King, Soman, & Lischuk, 2011), mock or scorn (Phillips & Clarke, 2012), harassment, discrimination, assault (D'Eon, Lear, Turner, & Jones, 2007), demeaning behaviour (Leape, Shore, & Dienstag, 2013), intimidation (Anderson, 2013), public chastisement (Musselman, MacRae, Reznick, & Lingard, 2005), unacceptable behaviours (Scott, J. et al., 2008) and offensive, intimidating and insulting behaviour (Imran et al., 2010).

Identifying specific humiliating and abusive behaviours

We sought to identify specific behaviours encompassed within the broad labels of humiliating and abusive behaviour. Sheehan et al. (1990) reported the subtle undermining of students' abilities and motivation that occurs through sarcastic and derogatory remarks, direct verbal attacks (yelling and shouting) and nasty, rude or hostile behaviour. Silver and Glicken (1990) also noted rude remarks, insults and students being told they were worthless or stupid, as well as being spoken to or about harshly or unjustly. Rudeness according to Baldwin et al. (1991) referred to public humiliation, being harassed, threats and insensitive remarks. Students being publicly belittled or humiliated and sometimes even threatened with physical harm has also been identified (Kassebaum & Cutler, 1998).

In a more recent qualitative study, Lempp and Seale (2004) named bullying behaviours, especially related to students being asked questions they were unable to answer, and

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approaches to teaching that the authors referred to as haphazard instruction. Around the same time, Rautio et al. (2005) found shouting and yelling were the most common forms of belittlement and humiliation.

Using a different methodology (narrative analysis), others identified students' experience of humiliation when, for instance, they were told "No!" on arriving at the door of a clinical setting for a legitimate observation activity as part of their course (Karnieli-Miller et al., 2009). A very recent survey of students reported their experience of being passed over, ignored or unappreciated, and feeling as though they were obstructing the work routine of someone in a teaching or supervisory role (Gagyor et al., 2012). The term "pimping" is employed by some students to refer to an aggressive way of questioning, putting students on the spot and shaming them (Anderson, 2013; Zou et al., 2011). There are other, more subtle behaviours that teachers use, such as refusing to answer learners' questions, not returning calls or answering pagers and using condescending language (Anderson, 2013). In this same category, others found behaviours such as threatening a trainee's reputation or career, unjustified criticism of their work, as well as sarcasm, teasing, withholding necessary information, ignoring and setting impossible deadlines (Daugherty, Baldwin, & Rowley, 1998).

Understanding the extent of the problem: Prevalence and people

Much of the early empirical research into the persistence of abuse in medical education has been survey-based, revealing high rates of reported abuse, often as high as 85% (Baldwin et al., 1991; Frank, Carrera, Stratton, Bickel, & Nora, 2006; Rautio et al., 2005; Sheehan et al., 1990; Silver & Glicken, 1990). In one study where 38% of students had reported being publicly humiliated, the researchers concluded, "The pattern of student abuse is largely unabated," with no decline in students' references to harassment in medical school accreditation visits over the preceding decade (Kassebaum & Cutler, 1998, p. 1150).

Abusive behaviour necessarily involves "perpetrators" and "victims" (Spencer & Lennard, 2005). Most abuse of medical students is perpetrated by senior and junior medical staff (including medical teachers and professors in classrooms and clinical settings) in hospitals and other practice settings; however, nurses have also been frequently named and thought to be increasingly the perpetrators (Kassebaum & Cutler, 1998). For some students, accompanying a doctor who is abusive or disrespectful towards a patient or another student is a disturbing experience (Karnieli-Miller et al., 2009; Sheehan et al., 1990). Research into the "victims" of abuse in medical education has found that senior students, who spend most of their time in the clinical setting, are more likely to be abused than junior students, who spend limited time in these settings (Al-Hussain et al., 2008; Silver & Glicken, 1990).

There have been studies over the past three decades seeking to identify gender differences in experiences of abuse, but these have not produced consistent findings. Some research identified higher rates of abusive behaviours towards females (Gagyor et al., 2012; Kassebaum & Cutler, 1998; Nabi, Harley, & Murphy, 2012), and one study found males reporting higher rates of mistreatment than female healthcare students

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(Al-Hussain et al., 2008). Other studies have found no significant differences between rates of abuse of males and females (Frank et al., 2006; Rautio et al., 2005).

One persistent concern in the literature is that self-reports of abuse in medical education are assumed to be subject to "over-reporting" (Rautio et al., 2005). However, in an early study, Sheehan and colleagues (1990) found that although 85% of students reported having been abused, only 16% had reported the abuse, and victims were often ridiculed. More recently, Dyrbye, Thomas and Shanafelt (2005) found that less than one-third of victims report abuse and that under-reporting was due to lack of awareness of reporting procedures, suspicion that the report would not be acted upon and fear of retaliation. A recent study found some students were advised against reporting the abuse they had experienced (Rees & Monrouxe, 2011).

Explanations posited

Understatement and denial

Some leaders in the field believe "the prevalence of this malign approach to teaching is declining at least at the undergraduate level" (Spencer, 2005, p.868); however, Silver (1982) and Silver and Glicken (1990) cited their earlier study that found that physicians acknowledged the existence of abuse in their medical school but the deans denied it. Another study with junior doctors in training found they perceived their intern year as a trial by fire, but members of the medical hierarchy tended to understate the prevalence of serious house-staff distress. The authors concluded that the degree to which the prevalence is underestimated increases as one moves up the hierarchy (Daugherty et al., 1998).

The cultural context

Through a socio-cultural framework, learning and development are seen to occur through participation in community activities (Kaufman & Mann, 2007). This framework was both explicitly and implicitly employed in the literature we reviewed. For example, Sheehan and colleagues (1990) commented that, when interacting with students, clinical staff often "fail to extend the same common courtesies as they do for other staff" and noted the extent to which students witnessed poor conduct on the part of their colleagues and clinicians in medicine. The authors expressed concern about the long-term corrupting influence on students who would soon become doctors (Sheehan et al., 1990). In the same year, Silver and Glicken (1990) discussed incidents of abuse representing a widespread pattern of behaviour in medical school. In his commentary, Greenberg (1990) noted that medical student abuse dates back to the apprenticeship model that existed before medical schools were established, and Kassebaum and Cutler (1998) named a "transgenerational legacy" (p. 1149).

In the study of intimidation in medical education and training in psychiatry, Tibbo, deGara, Blake, Steinberg and Stonehocker (2002) noted that "historically, intimidation had been perceived as part of the medical training process, a 'rite of passage'" (p. 562). This notion of the "rite of passage" is discussed in another study,

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where junior doctors were found to perpetuate a standard of behaviour to which they had become inured as students; the authors highlight that the surgical culture seems to permit behaviours that are unacceptable elsewhere (Musselman et al., 2005). In the study by Lempp and Seale (2004), the hidden curriculum of medical education is explored, wherein teaching that involves humiliation exists in a hierarchical and competitive medical education culture, and students learn the implicit rules of survival. Gaufberg, Batalden, Sands and Bell (2010) saw that it is through the hidden curriculum that students come to know their place in the hierarchy so they contribute to sustaining the dominant culture of medicine.

Spencer and Lennard (2005) maintained that practices that involve teaching by humiliation promote a culture of bullying and perpetuate a cycle of abuse wherein victims become perpetrators. These behaviours and explanations are shared across societies, too. Imran et al. (2010) noted that in Pakistan teaching by intimidation and practices that foster "a bullying culture" are prevalent (p. 594). In a finely grained exploration of this, Rautio et al. (2005) noted a way of thinking about this, wherein the moral order in each disciplinary culture is seen to determine what is "normal and ordinary and what is impossible, imaginary or extraordinary" (p. 2). They suggested that the power and control culture in medicine is one of the reasons for the mistreatment of students. These authors postulated that the values and behaviours of the future medical workforce develop out of the attitudes adopted during university studies. Neville (2008) noted that we have more than 20 years of publications documenting medical student harassment but that "in the age of professionalism student harassment is alive and well." Neville reasoned that mistreated medical graduates "meet unto others what was perpetrated against them" and concluded that "a subtle or not so subtle undercurrent of student harassment is continuing in medical schools around the world" (pp. 447–448).

Rees and Monrouxe (2011) examined what is experienced as the "dog-eat-dog" culture in medicine, particularly in surgery, where aggressive, abusive individuals create an abusive culture. In their student survey, Phillips and Clarke (2012) found a loss of idealism, emotional neutralisation, acceptance of the hierarchy and values modelled by teachers that "shape the process of becoming a doctor" (p. 888). These values and norms, Mahood (2011) argued, are consciously and unconsciously transmitted to future physicians. Further, he maintained that these messages undermine the formal messages of the declared curriculum and, as a result, students often move "from civility and caring to arrogance and irritability" (p. 983). Phillips and Clarke (2012) suggested that students tend to question and "transform" themselves when they come across messages that are at odds with their own beliefs or expectations. When this happens, he believes they realign their values, adjust their career plans and attempt "to fit into the world of medicine" (p. 893).

In a recent commentary, Anderson (2013) maintained that physicians accused of being "disruptive" (swearing, physically intimidating students and generally "creating mayhem") are rare; therefore, he proposed it is more useful to focus on what is more common, more subtle "disrespectful" behaviour, such as "pimping," which can be

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thought of as the abuse of the Socratic teaching method that shames students. Looking at the implications for the healthcare system, Anderson suggested that the "root cause" of the dysfunctional culture that permeates healthcare and stymies progress in safety is the acceptance of disrespectful behaviour towards patients, staff and students.

"Good intimidation"

One attempt to explain the practice of abuse in medical education is Musselman et al.'s (2005) finding of a perception of "good intimidation" (p. 932). Their interviews with junior doctors revealed that they are willing to accept this abusive behaviour if they believe it is well intended. An example given is students' perception that, even though a particular behaviour might be scary, it is "good intimidation" if the content is important or the intimidation is used because the learner has not understood the content presented in other ways. The authors also found that some students misinterpret "public chastisement" and intimidating behaviour as "just redirection" (p. 927).

Limited pedagogical expertise

The fourth category of explanations posited is that teachers use techniques to humiliate students because they do not know other ways to teach. For some, the training of medical teachers is seen as one step towards achieving the "monumental task" of culture change (Greenberg, 1990, p. 1657); some propose that teachers need "tools" to prevent them from resorting to intimidation and harassment (Musselman et al., 2005), personal practice with positive reinforcers of learning rather than abuse (Kassebaum & Cutler, 1998) and an understanding of safe learning environments (Rautio et al., 2005). However, Neville (2008) argued that even though efforts may be made to "optimise medical teaching skills" (p. 448), the problem is more a cultural and institutional one.

What are the effects of humiliation and abuse?

Effects of abuse in medical education are seen to be experienced at individual and institutional or professional levels. One concern in the literature is the effect on medical students' mental health. Some students have reported that abuse had a marked effect on their well-being; many were affected for a month or longer, and the effects were similar to those suffered by children who are abused (Sheehan et al., 1990; Silver, 1982). Frank et al. (2006) recently found that those who had been harassed or belittled were significantly more likely to be stressed, depressed, suicidal, binge-drink and state that their faculty did not care about them; they were significantly less likely to be glad they had trained to become a doctor. More recently, Dyrbye, Thomas and Shanafelt (2005) found that abuse affects students' confidence, as well as their choice of specialty, sense of loyalty to the institution and care of patients if their mental health is affected.

It is not only the experience of abuse that affects students negatively. Sheehan et al. (1990) found that witnessing abuse of patients had a corrupting influence on students, and Karnieli-Miller (2009) found students were affected when they witnessed a doctor being disrespectful or behaving badly towards a patient, or when they were left in the

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room with a patient who had been treated badly. The students became fearful of posing questions, felt less motivated to be part of the medical team and suffered negative emotions (Karnieli-Miller et al., 2009).

Some see these effects as detrimental to the medical profession and students' professionalism. In one setting, 30% of mistreated students reported that they considered dropping out of medicine and would have chosen a different profession had they known about the extent of mistreatment of medical students (Rautio et al., 2005).

For medical students, an emphasis on and desire for professionalism conflicts with the behaviours modelled by some senior doctors, thus creating a dissonance between ideals and reality. Some students try to bury this dissonance and accept that their seniors expect them to become resilient; others reconsider career plans (Phillips & Clarke, 2012). These effects are exacerbated when students report disrespectful behaviour but find nothing is done about it—a silence that is replete with messages (Leape et al., 2013). There is an inherent contradiction seen in a profession that expects sacrifices that approach martyrdom but condones behaviours that have the effect of disempowering its junior members (Gaufberg et al., 2010).

Discussion and recommendations

Our purpose in conducting this review was to advance a contemporary understanding of "teaching by humiliation" in medicine in the context of a concern about the professionalism of the future medical teaching workforce. We identified "teaching by humiliation" as one of the terms used to research and describe abuse, mistreatment, harassment, intimidation and bullying. Our review draws attention to both the types of behaviours that these terms name and to the range of explanations that have been posited by victims, perpetrators, commentators and investigators.

While some efforts at policy and professional development levels have been reported (Fnais, 2014), our review draws attention to the prevalence of beliefs, denials, explanations and rationalisations that threaten to undermine these efforts and perpetuate the unacceptable behaviours by medical teachers. To achieve the required change towards a culture that does not accept abusive practices by medical teachers, we need commitment at the level of executive leadership in both medical schools and hospitals, and a continued research effort to understand and support the teachers and students. The hidden curriculum that condones abuse of medical students by their teachers and other healthcare practitioners needs to be aligned with the formal curriculum that promotes professionalism. This will not happen in the vacuum that exists where medical schools and hospitals are not well connected and where many doctors who teach medical students identify with the hospital rather than with the university (Barrett, 2013). While universities, on behalf of their students, may take the lead, work is needed with the teaching practitioners in the places where they teach students—that is, where students learn from doctors about how to teach.

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