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Legacy of Abuse in a Sacred Profession: Another Call for Change

Janet Rose Osuch, MD, MS

Medicine is a sacred profession. Those called to enter it are largely kind, compassionate, insightful people who understand the nature of suffering and want to live their professional lives in service to relieving it. Why, then, do I contend that there is a legacy of abuse in medicine? I will examine two specific and dominant themes to explain my position—the culture of silence that has until recently surrounded medical error, and the methods employed in medical education. Both involve the inherent asymmetry of power in relationships and misuse of that power. Both foster conditions that, if they do not actually breed abuse, certainly tolerate it.

Admitting Responsibility for Medical Error

The 2000 Institute of Medicine report, "To Err is Human," issued a compelling indictment against our profession, exposing multiple types of medical errors, and concluding that up to an estimated 100,000 patient deaths occur each year as a result of errors [1]. One of the elephants in the room of medicine had finally been exposed—that doctors, those most responsible for medical care, make mistakes. Although errors caused by carelessness, indifference, or lack of attention to detail are inexcusable to me, I recognize that most result from complex systems problems. This is not to say that we should not hold physicians, nurses, and other heath care workers accountable for errors, but that instead, we should recognize that most people who choose our field care deeply about their jobs and are devastated when a patient suffers because of a personal mistake. Rather than passing judgment but ignoring the error, blaming the person, or both, the entire team caring for the patient should be involved in discussing the error together, learning from it, and, ultimately, devising a plan to prevent a similar problem from occurring in the future.

Admitting personal responsibility for a mistake is difficult, especially when we are well-intentioned and doing the best we can. It requires honesty, humility, and courage. It also entails that we remain acutely aware of the asymmetry of knowledge and power inherent in the patient-physician relationship. When a patient suffers because something went wrong, it is human nature for that person and his or her family to want to understand what happened. Our legacy of silence in the face of medical error in medicine has been, and in many cases, continues to be a poignant example of how we misuse our superior knowledge and, hence, our status. The very least that a patient and family deserve in this setting is a compassionate and transparent explanation, sincere apology, and communication of a plan of action to ensure that the error is not repeated with future patients. Apologizing for a medical

mistake in this way is perhaps the most healing action a physician can take for the patient to whom it happened.

Abuse in Medical Education

I believe that asymmetry in relationships and the misuse of power explains another cultural phenomenon in medicine—the abuse of medical learners. In my own surgery residency, the culture of abuse was pervasive. I certainly did not feel singled out in this context; I witnessed daily infractions against my peers that often made me cringe. I took this culture for granted for years, although it saddened me a great deal. When I was a resident, I believed, naively, that this culture was peculiar to my institution, not profession-wide. As I became part of the world of academic medicine as an attending physician, however, I witnessed the abuse of medical students, residents, and patients many times, although I felt helpless to stop it. Recent publications document that the majority of students of today experience humiliation or belittlement during their medical education [2, 3]. What I am saying is that, even if we win teaching awards year after year, if we tolerate this abusive culture, we are part of the problem.

Two years ago, I took the position of assistant dean of preclinical curriculum at the College of Human Medicine at Michigan State University, causing me to reflect more seriously on the abuses that I experienced in my own education. Medical educators have written extensively about "the hidden curriculum," which I consider a euphemism for the emotional abuse of medical students. Although we tout the benefits of and expectations that students practice relationship- or patient-centered care, I contend, as have others, that taking this position is unsustainable when we simultaneously tolerate an abusive learning environment in medicine [2, 4]. Anyone who has been a medical student or resident understands the emotional devastation that this culture of abuse creates, a reality that was provocatively written about by medical students recently, and that often persists for years later [5, 6].

I care deeply about the profession of medicine and feel privileged to be a part of it. In writing these comments, I was therefore not surprised to find myself hesitating to articulate examples of what the words "culture of abuse" imply, almost as if writing the words would somehow break an expected code of silence. That this phrase represents a worse indictment of the profession than the exposure of medical mistakes is, in my opinion, an understatement. It is quite probable, in fact, that the phenomena of medical error and student abuse are deeply intertwined, as both involve abuse of power.

It is with difficulty that I articulate the often dominant teaching culture of our profession, which is adversarial and based on intimidation, public humiliation, harassment, belittlement, and fear, especially in the clinical years [4-8]. This is an international phenomenon, and one that includes not only physicians, but other professions in medicine as well [3, 9]. Students are expected to know the answers to every "pimp" question without faltering, defer to the deeply entrenched hierarchical structure even in unfair situations, and never question their superiors, even when the

latter are exhibiting overtly unprofessional behavior. The consequences of this culture are predictable—low self-confidence, anger, cynicism, emotional disconnection, and depression [4, 7, 10]. How can this fail to result in disconnection, neglect, or even abuse toward patients, those in the system who are by far the most vulnerable in the hospital hierarchy?

We all entered medical school as optimistic, compassionate people. Many of us, including me, emerged from residency with cynicism and doubt about whether medicine could be as fulfilling as we had anticipated. We have been victims of the educational culture to one extent or another, whether we admit it or not. This, however, is no excuse for continuing its legacy. Instead, we must reframe the culture in which we teach our students so that we offer them the same respect, honesty, and kindness that we expect them to extend to their patients.

This is not to suggest that we should lower our standards and expect less than excellence from the learners of our profession, but that we dedicate ourselves to creating a consistent environment of interconnectedness between students and faculty [4]. It is a great privilege to interact with the future physicians. Our learning environment should foster intellectual inquiry that supports emotional and academic growth and is mutual, recognizing that our students have much to add to our own level of knowledge. Teachers are powerful role models. The environment we create should embrace, rather than diminish the spirit of the learner.

A Moral Imperative for Medical Educators

This is a call to medical educators to take definitive steps to cease tolerating the culture of abuse in medical education and view it as unacceptable. The call has been issued previously but has not been heard loudly enough to initiate substantial change [4, 11-14]. Medical educators have a moral imperative to create a culture of caring and respect in the field and to recognize the need for organizational and institutional change [3, 13].

We must have the courage to recognize not only that we commit medical errors in our care of patients, but that, by tolerating an abusive educational system, we commit errors toward our students as well. We must have the humility to accept the power differential between students and ourselves, understand the ease with which this power can be abused, and reflect each day on our interactions with students and residents to achieve self-improvement [15].

Most people who choose to teach are passionate individuals who care deeply about medical education and have been victims of an abusive educational system. Rather than passing judgment but ignoring an abusive incident, medical educators can create both informal and formal mechanisms to function as an educational team, address the incident together, learn from it, and take steps toward preventing a similar problem for future students. Intercollegial, nonjudgmental feedback based on mutual respect and goals for change is the key to the success of this endeavor. For the aggrieved learner, a discussion of the incident and the receipt of a compassionate and sincere

apology that recognizes the learner's personhood is perhaps our most healing offering. It will require the same amount of honesty, humility, and courage that we offer patients, if not more, because our educational errors are often an indictment of our behavioral and professional, rather than our intellectual or technical shortcomings.

Personal Coda

Events from my own life illustrate these themes. Having practiced medicine as a general surgery resident or academic physician for 19 years, I believed that I understood the best and the worst of medicine when I entered the hospital in March 1998 to have neurosurgical intervention for a 6-centimeter vestibular schwannoma in my brain. I was wrong. My 19-day hospitalization taught me many lessons. Certainly the most profound of these was the depth of the vulnerability that a patient with a serious illness feels. Although encounters with kind, compassionate, technically competent, and caring people were the norm during this time, my hospitalization also included serious surgical complications, medication errors, and communications of indifference or, uncommonly, even abuse from doctors, nurses, and other members of the health care team. When I contemplate my illness, what continues to bring me the most emotional pain are not the physical complications that ended my career in surgery, but the emotional abuses that I suffered. Although they were infrequent, their impact was far from trivial. Try as I might, it has been impossible to separate the pain of those incidents from those that I suffered as a resident. The interconnectedness between patient abuse and abuses in medical education became an inescapable reality for me.

I vividly remember the conversation that I had with my attending physician and the chief neurosurgery resident about a medication error that resulted in a serious complication. Although the attending physician was professional, responsible, and apologetic during the conversation, the senior resident was not. Instead, I would characterize his exchange with me as arrogant, defensive, and dismissive. The asymmetry between us—me the debilitated patient with an intracranial hematoma who could not ambulate, and he, a towering figure in a white coat—was not lost on me. I wondered though, is it possible that his own endurance of 5 years of neurosurgery residency had taken a toll on his ability to extend a compassionate response to me? What abuses had he suffered, and how might they have made him so incapable of a kind, professional response?

In deep contrast, one of the most profound interactions I experienced during that same hospitalization was with a much younger physician whom I didn't even know. The night before my operation was a fearful, vulnerable time for me, and I had trouble falling asleep. I hesitated to call for a sedative, remembering how often my restless nights as a resident had been interrupted by a sleepless patient. I felt sure, however, that a sedative had already been ordered for me when I rang the nurse's bell close to midnight. Imagine how I felt when I found the neurosurgery resident standing at my bedside shortly thereafter. In the darkness of the room, he asked how he could help me. I told him that I must be nervous because of the upcoming surgery,

that I couldn't sleep, and that I was mortified that he was losing sleep because of my request. He took my hand and told me that he would feel better knowing that I felt better. It was a simple interaction that lasted seconds, yet it was one of the most powerful experiences that I had in the hospital, holding meaning for me even 10 years later. This compassionate resident, in contrast to the first, understood my suffering and undoubtedly felt fulfilled by my grateful response to him. It is likely, however, that he had not yet had to tolerate the years of abuse that the previous resident had suffered.

I contend that, in good conscience, we cannot let this situation continue. We must attend to, value, and preserve the compassionate qualities with which our students enter the profession. I believe that Robert Michels says it best: "The nurturance of the physician's soul is the function of medical education" [16]. The wisdom of this insight empowers us in a profound way. We must follow its imperative. Just as we expect relationship-centered care for our patients, we must engender a culture of relationship-centered learning in medical education [4].

Attempts to change any culture require commitment, continuing and sustainable leadership, and a recognition that cultural change does not come quickly. As medical educators, we must collectively provide this leadership. The future patients and learners of our sacred profession depend on it.

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Janet Rose Osuch, MD, MS, is a professor of surgery and epidemiology at the College of Human Medicine (CHM) at Michigan State University in East Lansing. She devoted her clinical practice to breast surgery prior to her illness in 1998 and subsequently pursued a degree in epidemiology. Dr. Osuch currently serves as the assistant dean of preclinical curriculum at CHM, where she also practices breast-cancer-risk counseling and conducts epidemiologic research.

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