



Medical Students' Experience of Negative Communication by Superiors in a Clinical Setting

Avital Fischer^{1*}; Johanna Shapiro²; Brenda Geiger^{3*}

¹Resident Physician in Psychiatry Stanford University Department of Psychiatry and Behavioral Sciences 401 Quarry Road, Stanford, CA, 94305, USA.

²Department of Family Medicine University of California, Irvine- School of Medicine Address: 1001 Health Sciences Rd, Irvine, CA, 92617, USA.

³Department of Behavioral Sciences Western Galilee College Akko, 2412101, Israel.

***Corresponding Author(s): Avital Fischer¹ & Brenda Geiger²**

¹Resident Physician in Psychiatry Stanford University Department of Psychiatry and Behavioral Sciences 401 Quarry Road, Stanford, CA, 94305, USA.

²Department of Behavioral Sciences Western Galilee College Akko, 2412101, Israel.

Tel: 757-757-1074; Email: avitalf@stanford.edu & BrendaG@wgalil.ac.il

Abstract

Medical students enter medical school fired with idealism which has been shown to decline in clinical years in a hospital setting with a hierarchy of authority that increases the risk of maltreatment by superiors. This qualitative study examines the personal experiences of medical students in their 1st clinical year when facing negative communication by seniors in a hospital environment, and the consequences of such interactions on their sense of competence as future physicians, their wellbeing and idealism.

Methods: 29 medical students at the end of their first clinical year participated in the study. Online self-administered interviews asked students to reflect on their challenges in communication, mentorship and guidance, and how these challenges affected their sense of competence and priorities as future physicians. Themes and subthemes were identified via inductive content analysis.

Findings: Students reported lack of preparation, direction and mentorship. Putdowns, sarcasm, and derisive comments were part of their interactions with superiors (residents and attendings) yet seldom labeled as maltreatment. Negative interactions resulted in feelings of powerlessness, isolation and exhaustion that impacted their sense of competence and ability to attend to their patients. By the end of the first clinical year, students reported becoming cynical and doubting their original idealism reasons for pursuing a career in medicine. When facing the reality of the hospital setting and its impact on their wellbeing, they shifted their priorities from total dedication to patient care to finding a residency specialty in which they could strike a balance between work and their wellbeing.

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Conclusion: Maltreatment of medical students in their clinical years, although banned continues in the hospital setting, contributes to students' exhaustion, and burnout with resultant cynicism and doubts in the idealistic pursuit of patient care. Increasing the awareness of verbal maltreatment, training medical staff in respectful communication, and implementing a strict code of ethics that bans maltreatment and allows easy reporting are expected to improve the climate in teaching hospitals, increase students' wellbeing and restore their idealism.

Introduction

Medical students enter medicine fired with idealism, empathy and, a sense of mission to understand and cure disease and alleviate human suffering. While the first two years of medical school are structurally similar to pre-medical undergraduate education, the clinical years are very different and students report being generally unprepared to face challenges of a hierarchical hospital setting with very different demands [1]. They seldom know what is expected of them, have very few internal criteria of self-evaluation [2,3] and depend on their superiors to evaluate their abilities, achievements, and competence as future physicians which increases their vulnerability to negative feedbacks and comments [1]. This study focuses on negative comments by supervisors that are perceived by students as attacking their sense of self, abilities and competence as future physicians. Such comments have been referred as verbal abuse or maltreatment [1] which encompasses acts of commission such as ridiculing, overtly criticizing, constantly correcting, interrupting, belittling, predicting failure and humiliating comments as well as acts of omission such as ignoring, prolonged silence, refusing to answer and withholding attention [4,3,5]. Prior surveys of medical students in their clinical clerkships reported ignoring, denying communication, belittling and humiliation as the most common forms of verbal abuse/maltreatment perpetrated by superiors [6-10].

In 2004, Medical schools have adopted standards of conduct that formally ban any form of maltreatment. The Association of American Medical Colleges (AAMC) Ad Hoc Committee of Deans Report emphasized the responsibility of academic medical leaders to train competent and humanistic physicians while promoting medical trainee wellness and combating burnout. Despite the formal declaration, verbal maltreatment by superiors continues and is seldom reported [11]. In the 2016 AAMC Graduation survey (2018) [12] more than one third of the medical students reported experiencing maltreatment in their medical education. However, 80% of them chose not to formally report the incident [13]. Similarly, in the 2022 Medscape Medical survey of 1500 physicians, 86% of the respondents had observed bullying or harassment among fellow clinicians and staff, and 49% of them agreed that abusive physicians should be verbally warned. However, only 27% of the respondents were ready to report such maltreatment.

Studies show medical students are often reluctant to report maltreatment by superiors for fear of damaging their relationship with them, fear of reprisal, and the fear of endangering their future training and job prospects. Other reasons for not reporting were related to students' belief that maltreatment was part of the clinical training culture and consequently students, at times, failed to recognize that such a practice is unethical and must be reported. Finally, the lack of a formal mechanism of

reporting and of prompt responses coupled with the belief that the reporting process is time consuming and troublesome were additional reasons for not reporting [13,9,5].

Verbal maltreatment by superiors compromises medical students' psychological security emotional well-being and sense of efficacy as future physicians [14,9]. Negative communications by superiors results in distress, shame and humiliation of the targeted students and ultimately in their exhaustion and burnout [7,14,10]. Burnout has been characterized by emotional exhaustion, de-personalization, cynicism, and loss of confidence in oneself and one's ability to achieve [7,9,15-17]. Multi-center surveys with medical students in their clinical years indicated that interactions with cynical and humiliating residents and lack of clerkship organization were the main predictors of student burnout [14,18,19,17]. Drawing from Social Learning Theory, medical students are also likely to model their seniors and engage in abusive forms of communication when interacting with other medical students [9]. Hence, the risk of passing from one generation to another a culture of maltreatment in the clinical years of medical education [9,5].

Silver (1982) [20] was the first to draw attention on the impact of maltreatment on medical students' ideals of care and could not fail to observe that they had "become cynical, some dejected, others frightened or depressed, and a few filled with frustration" (p. 309) with significant decline in empathy and care. Other researchers also explained that to surmount the reality faced, medical students shut down kindness and empathy and thereby run the risk of undergoing traumatic de-idealization, a process that transforms them into uncaring physicians. unable to provide quality care to their patients [21,22,15,23].

Studies on verbal abuse/maltreatment of medical students in their clinical years have commonly been based on multiple choice survey questionnaires with standardized responses that constrain the respondents into forced choices and seldom give them the opportunity to voice their own opinions [24,25]. In line with Patton (2002) who argued that to judge the effectiveness of any educational program, "it can be as important to understand the stories behind the numbers as to have the statistics themselves" our research efforts concentrated on those often invisible but most important actors of the future of medicine - medical students in their 1st year of clinical training. By giving them a voice, we wanted to find out in their own words and from their own perspective their experience of being the target of verbal abusive comments by superiors and the impact of such abuse on their self-esteem, sense of self efficacy as future physicians, their motivation to learn and future plans and priorities as future physicians.

Material and Methods

Sample recruitment

The present study was approved by the IRB #2015-178 of one of the California medical schools and was part of a larger survey on mindfulness and empathy that 100 medical students were required to complete at the end of their 1st clinical year. An email was thereafter sent to all these students inquiring whether they had experienced negative communication with superiors. In such a case they were invited to participate in an online anonymous interview. We stated the goal of our study was to evaluate challenges in communication with superiors when starting their clinical years and the impact of these challenges on their motivation, sense of self-efficacy perception and

life priorities. After three consecutive emails, 29 students consented to participate in the study.

Research tool

The preferred tool for this study was an online self-administered interview with open-ended questions. We expected that medical students in their clinical years would feel less threatened or embarrassed to address the sensitive and seldom reported-topic of abusive communication online as opposed to during face-to-face interviews [26,24]. The open-ended online interview included the following questions: (1) Could you tell us about your challenges upon entering the hierarchical structure of the hospital setting? (2) How did you feel, think and react when subjected to negative comments and maltreatment by seniors? and (3) How did such experiences impact your sense of competence, motivation and priorities in the pursuit of a career in medicine.

Procedure

Prior to obtaining consent the researchers specified that participation was voluntary, and anonymity would be protected by replacing all names and identifying information in their narratives by pseudonyms. Once consent was obtained, the link for the online self-administered interview was sent by email to the participants. The research tool chosen was expected to increase openness, and thereby, enable students to provide more elaborate and meaningful answers on topics that they often fear to address because of their repercussions on their performance evaluations [26,24]. Participants were directed as follows: There are no right or wrong answers, we would like you to take time to reflect on your experiences in the first clinical year and answer the questions as elaborately as you can.

Content analysis

Students' narratives were analyzed through thematic inductive analysis [27]. Two researchers analyzed the data in order to avoid any potential bias related to one researcher's analysis [28]. Each researcher separately read participants' answers to each of the questions to inductively identify and highlight themes and subthemes related to the question. Inter-analyst disagreement on any theme or sub-theme was discussed until consensus was reached. We must emphasize that our analysis relied only on the subjective meaning and interpretation that the participants gave to their common experience of interacting with superiors during their 1st clinical year [29,30]. All inductively drawn inferences were supported with direct content-rich quotes the participants' own words.

Results

Coming unprepared to the structure of the hospital environment

A recurring theme in students' narratives was feeling thrown upon entering their 1st clinical year in a unfamiliar hierarchical hospital environment with its own rules and practices. In the words of interviewees:

"Unfortunately, the challenges I faced don't have easily gained skills to overcome them. I knew what I should/needed to do, but didn't always have the time, confidence, etc." Int. 11

"I'm not sure anything can prepare you to the clinical years" Int. 26

They also reported that no one was interested in finding

out who they were and what they knew and the fear that they would be judged as incompetent when in fact they were totally disoriented,

"When you start 3rd year, nobody (residents, attendings, ancillary staff) has any sense for where you are in your training. You're consequently set up to appear incompetent when you're really just disoriented as you navigate a new system, EMR system, building, team, etc." Int. 28

Lack of guidance and mentorship

Most of the students interviewed reported a lack of mentorship and constructive feedback. They felt that they were constantly judged and evaluated while unable to know whether the superior who had evaluated them actually interacted sufficiently with them given the evaluations were anonymous. In their own words

"Evaluations, which are incredibly valuable to medical students since they are visible to residency programs, felt sloppy relative to the amount of effort exerted by medical students. It felt like some attendings only submitted evaluations if they had something inflammatory to say. Additionally, evaluations were anonymous which certainly promoted writing feedback that was never verbally communicated. This also made it difficult to assess if evaluations came from individuals you worked with for weeks and whose opinions you really valued, or someone you spent a half day with and would never view as a mentor." Int. 28

"I specially felt the lack of guidance and mentorship. I didn't know whom to go to for questions. There was an evident lack of constructive feedback, and the feedback on evaluations did not match with what I was told during the rotation." Int. 5.

The challenge of facing indifferent and abusive faculty and self-serving classmates

The interviewees reported facing self-serving classmates and indifferent faculty. Some of them described their classmates, residents, and faculty as malicious, mean, and lacking integrity. In consequence, they no longer knew whom to trust or look up to.

"I had to navigate between malicious and self-seeking classmates on rotations and some indifferent or even malicious faculty. I spent lots of time figuring out whom I could trust and identify the mentors I could look up to. Int. 2.

"Not the medical knowledge part, but the interactions I saw and facing occasional mean residents or attendings. They impressed me, surprised me, even outraged me." Int. 9.

"Pimping on rounds often felt like a blood bath of who can look best in front of the attending. It created a culture of competition rather than promoting learning or space to make educated guesses." Int. 29.

"Once an entire morning went by with my senior resident completely ignoring me despite multiple attempts to engage. That same resident referred to me as "the med student" throughout the rotation, which made for a painful three weeks." Int. 20.

Impact of maltreatment on self-efficacy perception

Several participants reported that the lack of trust, sarcasm, and constant feeling that they were judged and evaluated had impacted their ability to safely ask questions, voice their opinions or disagree without feeling humiliated or stupid.

"It was very hard to know when and to whom to ask questions, and when it was ok to look up something on my phone and what was expected from me. Int. 27.

I learned the hard way that there was no place for me to bother the senior physicians with "stupid questions." Int. 20.

"There were also challenges in figuring out where and/how to say something when you do not necessarily agree and balancing your desire to function well within the team and ultimately receive a fair evaluation." Int. 11.

They soon came to understand their comments or corrections could be misinterpreted as defying authority.

"I found myself correcting my attending on rounds on a question of conversion from inches to centimeter. He later asked me to come to his office and told me that in life I need to choose between being right and being happy." Int. 25

Consequences of maltreatment

Feeling powerless

Participants reported feeling powerless when facing overbearing and antagonistic residents. In the words of one of the interviewees,

"I felt powerless and unable to express: 1) what was right for patients 2) my thoughts about their poor decisions and 3) their lack of social/communication skills. Micro-aggressions toward medical students from residents are rampant in the clinical context." Int. 20.

The feeling of powerlessness was exacerbated by the medical education administration refusal to acknowledge superiors-attending, residents and nursing staff negative interactions with their students who became intimidated, humiliated, and no longer dared asking questions.

"The medical education administration refuses to directly acknowledge the hierarchy of power which is very problematic since it forces students to be in an uncomfortable position that may impair their reputation and grade. Because of the desire to learn they ask questions and have their questioning be misinterpreted as being a bad medical student" who is "unprofessional." Int. 27.

"The administration is unable to deal with different communication problems ranging from indifferent to abusive teams, nurses and even staff in the hospital." Int. 5.

Feeling insignificant and useless

Others added feeling infantilized and insignificant as they were expected to do clerical work rather than learn and practice medicine.

"The worst was being treated like a child when I'm an adult." Int. 18.

"It was difficult to navigate different personalities and be treated like I did not matter at all. I was moved to a different computer to work on because I was a medical student whose work was not important." Int. 27.

Many felt constantly in the way, and not worth the time of their seniors, In their own words, "Feeling like I was in the way or being used by residents purely for administrative tasks like faxing and looking up data." Int. 5.

"Seniors in the hospital make 3rd year students feel that they are constantly in the way, that they are stupid, and that they aren't worth the residents' time. This presents a challenge and makes it hard to find a support system." Int. 24

Sense of isolation

The great majority of interviewees reported a sense of isolation and exhaustion. Several of them attributed these feelings to the lack of teamwork and cooperation, and to the constant pressure to please antagonistic and at times cynical residents. In the words of the interviewees,

"One of the main challenges was confronting constant criticism and related feelings of isolation and powerlessness when facing antagonizing residents." Int. 26.

I felt very alone most of 3rd year because I felt under the constant pressure to please. I was so exhausted every day. I had no time or place to reflect on the stress and difficult situations I saw." Int. 5.

As a new 3rd year medical student, I failed my first shelf exam. I did not feel that I could seek help or support from many fellow medical students. The desire to only advertise successes and bury failures was significantly amplified during the 3rd year of medical school and led to unimaginable isolation. Int. 28.

Exhaustion

"You feel as though you must appear enthusiastic and interested all the time, as you're continuously evaluated and judged for everything from your patient presentations to your non-verbal behaviors. Contrast this with the fact that you are brutally aware that if you were not to show up the next day due to illness (which would certainly be seen poorly), none of the daily workflow would change. This translates into both physical and emotional exhaustion throughout the clinical years." Int. 29.

Impact on competence

Other participants reported that the lack of trust, the constant criticism when at the lowest rung in a hierarchy of authority had affected their self-esteem, and sense of competence while increasing their sense of isolation and exhaustion.

"I do not think there was enough time to process everything I observed during the day, and I didn't realize how much it was weighing on me. I felt isolated from classmates and the lowest person on the totem pole which was somewhat hard on one's self-esteem and mental well-being." Int. 9.

"I feel like 3rd year made me doubt myself and my knowledge more than I ever have in the past." Int. 22.

Coping strategies: disengagement

Some of the participants' coping strategy to preserve a sense of self and competence as a learner was to detach themselves from the evaluations and feedback of their superiors.

"Never blindly trusting feedback of any kind, both good or bad: Judging carefully for myself what feedback is worthy and what feedback I know is not true." Int. 2.

Another strategy participants reported was to freeze their feelings and become emotionally disconnected to protect themselves from arrogant attending physicians whom they felt could care less about their progress,

"I had the challenge of working with some arrogant and curt attendings who didn't care much for students. I developed a thick skin in my 3rd year of medical school. And I am very glad for it." Int. 4.

Impact of maltreatment on the ability to communicate with patients

The participants also stressed that lack of teamwork, poor guidance and power differentials had negatively impacted their ability to communicate with their patients. In their own words,

"I kept on trying to maintain respect for patients at the expense of not bonding with my team. I felt being forced into poor communication problems because of lack of proper explanations and guidance from seniors." Int. 18.

"I felt at times that the doctors failed to communicate with us and recognize that there was an evident gap in understanding." Int. 10.

Lost expectations

Participants stressed the desperate need for attendings, residents and other mentors who listen to them and help them build a sense of confidence rather than humiliate or ridicule them.

"Finding mentors or peers who genuinely care and are confident in themselves and want you to succeed too and not having to hear or deal with pervasive microaggression." Int. 2.

In contrast, participants who on rare occasions had worked with compassionate attendings reported how elated they had been by the increased opportunities for learning and serving their patients.

"And then I had the opportunity to work with some wonderful attendings who were passionate about teaching. I learned to be open-minded and find my own opportunities for learning, always in the service of my patients." Int. 4.

Loss of idealism

Participants also reported that entering the first clinical year they realized that the overreaching goal of medicine to which they were committed was treating people. However, by the end of the 1st clinical year, the long working hours and the fast pace of moving from one patient to another with limited time for face-to-face interaction and endless notes had shattered their idealized view of medicine. In the real world of the hospital setting there were long working hours and endless paperwork leaving little time to listen and counsel patients. In their own words, "More and more I realized the concern with medical billing and started doubting if I will be able to practice medicine in the way I envisioned where you have enough time to counsel patients. Engaging in personal contact with my patients while providing active empathetic listening was not realistic within the constraints the current medical system". Int. 18.

"Third year, in my opinion, clouded the idealistic vision of "helping people". That objective becomes associated in the student's mind with paperwork, long hours, not enough sleep, feeling like you are in elementary school (They have to tell you each day when you are allowed to go home), subjective evaluations, etc.,." Int. 14.

Feeling insignificant, useless, constantly reprimanded and engaging in paperwork while seldom having enough time for

direct patient care coupled with the realization that they could not change anything had led to their cynicism,

"I certainly became more cynical. Being in the hospital that is so resistant to change and makes you feel so insignificant makes you realize that wanting to change things is a waste of time and energy. You will be treated like you do not matter at all." Int. 10.

Shifting priorities

After facing the "real" world of medicine, most of the participants reported they had changed their priorities. Their focus had shifted from idealistic motivations to help and heal toward choosing a specialty that would allow them to strike a balance between providing patient care and maintaining their own well-being by optimizing work hours and compensation.

"Specialty choice changed, which in a way changed the specific reasons for becoming a doctor, but not the overall concept." Int. 11.

"The altruistic Intentions of our profession often times seemed quixotic in the face of real-world medicine." Int. 6.

Discussion

The present qualitative study gave a voice to medical students expose their perspectives and experiences during their first year of clinical training when ignored, humiliated and mistreated by superiors who rarely provided any positive feedback. Despite students idealistic motivations to help and heal when entering medical school [31,32] they were unprepared to face the reality of the clinical rotations and the hierarchy of authority in which they were at the lowest level of the totem pole and at risk of being ignored or mistreated [33,1,9].

In line with prior studies [10,5] the present study shows that medical students in their 1st clinical year were subject to verbally abusive communication during which they were belittled, demeaned, ignored and humiliated by residents and attending physicians who made them feel inferior, stupid, and constantly in their way. Previous studies [34,13] show that students often failed to label negative interactions with superiors as abusive. Students in the present study often attributed these negative interactions to their inability to communicate properly with their superiors, and powerlessness in a hierarchy of authority in which those "higher-ups" were the ones to evaluate their competence as future physicians.

The findings of the present study show criticism, negative feedback and abusive comments from superiors coupled with competitive and sarcastic classmates produced a hostile climate that compromised teamwork. Constantly wondering whom they could trust, students tried to numb their feelings and distance themselves from those who evaluated or competed with them. The lack of psychological security and exhaustion when constantly having to please lowered students' sense of self efficacy and idealism in practicing medicine. It therefore is no surprise to find out that the first clinical year of medical training has been identified as a turning point in medical students' loss of idealism [21,31] and empathy [22] with increased rates of burnout, distress and decline in wellbeing [14,18,9,15,16].

The gradual process of burnout and de-idealization among medical students has been attributed to a hospital culture of maltreatment that is passed from one generation to another [21,9,35]. In the present study the hospital reality with long hours, unending paperwork and limited time to establish face-

to-face relationships with patients as well as the exhaustion of constantly trying to communicate with seniors while fearing putdowns, and humiliation had resulted in a drop of idealism, increased cynicism and burnout with a consequent shift in life priorities. Rather than absolute dedication to medicine and patient care, medical students interviewed in the present study had shifted priorities by the end of the 1st clinical year and sought a specialty that would allow them to strike a balance between patient care and their own well-being.

The ethical guidelines enunciated in AAMC Ad Hoc Committee of Deans Report (2004) [36] recommended banning maltreatment in all its forms and providing a forum wherein medical students could be heard without fear of punishment [37]. Despite these recommendations, verbally abusive communication by superiors continues to be part of the hospital setting with medical students failing to report such a maltreatment for fear of retaliation and consequence on their future as physicians [12,13,9].

Consequently, maltreatment to which medical students are subjected in their clinical years needs to be once more addressed. It is imperative to raise the awareness of faculty and residents about the importance of their mentoring role and the need to provide a positive climate with respectful communication to promote learning, growth and, teamwork rather than destructive communication and negative feedback that has detrimental consequences on student self-concept and sense of self efficacy as future physician.

Limitations

The present study included a limited sample size which was sampled from a single institution in South California. A more comprehensive study with a larger sample of students from other medical schools across the United States will allow to further validate our findings. Furthermore, although in-depth face-to-face interviews have been used to examine the common experience of participant, we selected an anonymized on-line interview as a preferred modality to evaluate the sensitive and seldom reported experience of verbal abuse by staff in the hospital setting. On-line interview with open-ended questions commonly increase openness of responses on sensitive topics [26,24] while preserving the anonymity of the participants and thereby, enable them to voice their feelings, opinions and challenges without fear of consequences.

Conclusions and recommendations

The findings of this study show significant barriers to an optimal initial clinical experience exhibited by insufficient mentorship, long work hours, verbally abusive interactions with medical residents and faculty and role confusion within a hierarchal organization. Therefore, we recommend expanding the medical education curriculum to prepare students to manage difficult situations encountered in the clinical setting. Above all, this study emphasizes the need to improve the academic climate at teaching hospitals while training clinical mentors and seniors on effective and respectful communication with students and on productive ways of providing constructive feedback. Also recommended is to clarify to the residents and attending physicians the role and duties of medical students in their 1st year clinical year. The implementation of new interventions to enhance a supportive climate that promotes teamwork and cooperation in the clinical setting will hopefully revive medical students' idealism and dedication as future companionate

healthcare providers.

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