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Investigating the Prevalence and Impact Of Incivility In Medical Schools: A Review of the Literature

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Abstract: Bullying and incivility negatively affect patient care, team interactions, and practitioner mental health. Prior research has highlighted the prevalence and outcomes of bullying for residents, physicians, and healthcare workers. This paper reviews research literature in order to understand the prevalence of bullying and incivility toward medical students.

Keywords: Incivility, medical students, bullying,

Introduction

Interpersonal interactions within health care settings impact clinician health and patient outcomes (Anderson, 2013; Lachman, 2014). Negative interpersonal reactions have been labeled as incivility, horizontal or lateral violence, bullying, disrespectful, harassment, or disruptive behaviors. These behaviors are manifested in an overt manner and include racial slurs, derogatory comments, belittling comments, or verbal harassment. It also includes passive behaviors, for example, a failure to answer pages, failure to comply with policies and non-verbal responses including facial expressions and negative body language (Petrovic & Scholl, 2018). Incivility has been examined across a variety of work environments and includes, emergency room departments (Klingbery; Gadelhak, Jergerlehner, Brown; Exadaktylos & Srivastava, 2018), nursing (Bambi, Guazzini, De Felippis, Lucchini, & Rasero, 2017) and residency programs (Leisy & Ahmad, 2016). Bullying has been shown to have negative consequences in respect to patient outcomes and studies show that disruptive behaviors can lead to adverse events (Anderson, 2013; Rosenstein & O'Daniel, 2008). Incivility can lower physician morale (Askew, Schulter, Dick, Rego, Turner & Wilkinson, 2012), increase team dysfunction (Blakey, Anderson, Smith-Han, Wilkinson, Collins & Berryman, 2018) and is related to negative mental health outcomes (Frank, Carrera, Stratton, Bickel & Nora, 2006). Evidence of bullying is also seen globally (Ahmer, Yousafzai, Bhutto, Alam, Sarangzai, & Iqba, 2008; AlMulhim, Nasir et al., 2018; Lau, Li, Llewellyn & Cyna, 2017). In order to understand how bullying behavior becomes normalized, we investigate the prevalence of bullying experienced by medical students.

Background

Bullying has been described in a number of ways in the research literature. For the purpose of this paper, the terms bullying and incivility are used interchangeably and are defined as "a persistent behavior against an individual that is intimidating, degrading, offensive, or malicious and undermines the confidence and self-esteem of the recipient" (Ahmer et al., 2008; AlMulhim et al., 2018). Bullying potentially affects patient care as well as staff morale (Anderson, 2013; Lachman, 2014). For example, residents who experience "pimping," a form of question and answers that belittles or humiliates respondents who provide incorrect responses, are less likely to disagree with supervising physicians even if they disagree with the course of treatment (Anderson, 2013). In respect to workplace outcomes, incivility has been shown to have a negative impact in professional settings such as emergency rooms as it affects personal well-being and team performance (Klingbery et al., 2018). Medical students, when bullied, experience higher levels of depression along with increased feelings of unworthiness and

incompetence (Szubert, Gibberd, Buisson, Hooker & Ivory, 2018). Interestingly, junior physicians and residents who experienced bullying may become perpetrators as they move up in seniority (Wilkinson et al., 2006).

Theoretical Frameworks

Theories of learning and identity development can help illuminate why bullying behaviors are adopted by those who were previously bullied and can provide insight into how these behaviors become pervasive in the workplace. Social learning theory and professional identity formation can provide insight into why bullying persists.

Social learning theory. Social learning theory (SLT) can be used as a lens to understand how and why bullying is replicated within the health care setting, SLT posits that learning occurs through the intersection of engagement with others, observation, and mental processes (Bandura, 1977). Wenger asserts that learning occurs within social structures and occurs within our workplaces as we engage in daily activities (Wenger, 1999). Through interpersonal interactions, we develop an understanding of professional expectations and modes of behavior. For example, within a doctoral program, students develop a scholarly identity though engagement with peers and faculty (Coffman, Putnam, Adkisson, Kriner, & Monaghan, 2016). Medical students learn through socialization with senior physicians who role model behaviors that related to interprofessional and patient engagement (Burford, 2012). Having a deeper understanding of how medical students learn through socialization can illuminate why negative behaviors become normalized and adopted by prior recipients of these behaviors.

Development of professional identity. Professional identity formation (PIF) stems from social learning theory and social identity theory (Burford, 2012). Professional identify formation refers to the adoption of an identity through curricula and interpersonal interactions (Wald, 2015). Wald (2015) argues that PIF "encompasses development of professional values, moral principles, actions, aspirations, and ongoing self-reflection of the identity of the individual" (p. 701). Professional values and moral principles are transmitted from senior to junior physicians, residents, and medical students. Viewed from a positive perspective, PIF enables physicians and trainees to view and adopt ethical behaviors, develop a caring attitude, and internalize humanistic values (Holden et al., 2015). However, if the same learners are exposed to negative behaviors, for example bullying, it is also possible they may adopt these characteristics if they are perceived as appropriate and normalized.

Since bullying behaviors occur across the professional spectrum and includes physicians, residents, medical students, as well as nurses and other members of the health care team it is important to consider how and when these interactional norms are introduced. In order to consider potential points of intervention, it is essential to have a better understanding of where aspiring physicians first experience bullying. There is significant research focused on bullying in healthcare teams, medical specialties, and nursing. There are fewer studies that focus on the experience of incivility with medical students in higher education and on the wards.

Methods

Screening Procedures. Articles in this review were required to meet the following criteria: (a) published in English in a peer-reviewed journal before October 1, 2018; (b) included medical students during training as participants; (c) included an examination of bullying or aggressive behaviors directed towards medical students; and (d) discussed original findings. Potential articles for this review was found by searching the electronic databases Academic

Search Complete, Academic Search Premier, Medline, PsychInfo, ERIC, Healthsource consumer, and Healthsource nursing and academic education using the search string (((("Contrapower Harassment" OR "incivility" OR "relational aggression" OR "horizontal aggression" OR "relational transgression" OR "bullying") AND ("healthcare" OR "health professional*" OR "doctor*" OR "physician*")) AND (Education*)) NOT (("child*" OR "Adolescent*")). This search resulted in 209 unique articles.

A screening on the resulting 209 articles was conducted by examining their titles and abstracts resulting in 49 articles that met the criteria for this review. Additionally, an ancestral search using the resulting articles was conducted along with a forward citation search using Google Scholar found five additional articles. After a review of the resulting 55 articles, nine articles were found to meet the criteria for this literature review.

Coding Procedures. After identifying the nine articles using the process described above each article was coded using three main category groups (a) study methods utilized, (b) relevant definitions utilized, (c) findings and implications, (d) racial, ethnic, national differences in sample. A more specific description of each variable is described below.

Study Methods. For each article, we recorded how bullying or aggressive behaviors was assessed (i.e., scale or observation) including format of given study (i.e., quantitative, qualitative, or other). Additionally, any unique research methods that made the study unique was included.

Relevant Definitions. For each of the studies included in the final literature review any relevant definitions for the final literature review were noted. These definitions included aggressive behaviors (e.g., bullying, cyber bullying, harassment) and others that related to the demographics of the samples examined (e.g., medical student, medical training). If definitions were cited to previous research, these sources were noted.

Findings and Implications. For each article, we noted the findings of each study along with any implications the authors mentioned within the results and discussion sections of the article.

Racial, Ethnic, National Differences in Sample. For each article the individuals that made up the given sample were noted. These factors included if the medical students came from a specific field, geographic location, or shared a common demographic.

Results

From the nine articles identified in the review of literature, a number of studies were identified examining a variety of medical students' experiences with incivility. These studies employed varied terminology to describe negative experiences medical students experienced from others during their training and this includes mistreatment and harassment (Baldwin, Daugherty, & Eckenfels, 1991; Blakey et al., 2018; Frank et al., 2006; Mangus, Hawkins, & Miller, 1998), abuse (Moscarello, Margittai, & Rossi, 1994), adverse experiences (Wilkinson, Gill, Fitzjohn, Palmer, & Mulder, 2006), and bullying (Ahmer et al 2008; AlMuljim et al., 2018). Despite the lack of cohesive terminology, it is evident that uncivil and bullying behaviors are evident in medical schools.

Baldwin et al (1991) conducted one the first significant studies in the area. They sent a questionnaire to senior medical students at ten US based medical schools and had 591 responses. Students indicated they experienced bullying by residents and attending physicians and the most common forms of mistreatment were public humiliation (87%), having their grades threatened (35%), and threatened with physical harm (26%). Additionally, the research showed that 9 out of 10 medical students reported senior physicians made negative comments about the entering the

medical field as a result of their own experiences with bullying. Mangus et al. (1998) also examined the prevalence of harassment in US based medical schools. Their survey was deployed to eight medical schools and they had 548 responses, similar to prior studies. Results showed that approximately 46% of respondents experienced some form of harassment during medical school. Additionally, this study found that 41% of the students reported that they were exposed to discriminatory behaviors by instructors or supervisors. Frank et al. (2006) expanded on this research and looked across 16 medical schools in order to understand if the prevalence of bullying differed across fields of study. Overall, they found that 42% of respondents experienced harassment but it was more prevalent in the sub-specialties of surgery, gynecology, and pediatrics. Similarly, Lazarus et al. (2016) found a greater prevalence for harassment of medical students in the areas of interventional radiology and general surgery and fewer incidences in general internal medicine.

Bullying is also evident in medical schools outside of the United States. Moscarello et al. (1994) surveyed medical students at the University of Toronto, in Canada. Out of the 347 medical students who responded, 68% experienced verbal or emotional abuse and alarmingly, 7% reported experiencing physical abuse. Findings are similar in New Zealand where Wilkinson et al. (2006) found that approximately 68% of medical students surveyed reported adverse experiences at school. Respondents of this study indicted the most common experience was humiliation and degradation followed by verbal abuse (yelling, use of profanity). Ahmer et al. (2008) surveyed medical students in Pakistan. Fifty-two percent of respondents reported being bullied and the most common behavior was in the form of verbal abuse. Similar results were reported more recently by AlMulhim et al. (2018) who examined students at a medical school in Saudi Arabia. The compared incidents of bullying in medical school to non-medical school students. In their study, 50% of non-medical school respondents reported experiencing some form of bullying compared to 44% of medical school students. Medical school students reported experiencing verbal abuse or being pressured to produce work.

We also focused on how each of the studies examined how bullying behaviors were influenced by gender, age, religion, or marital status. Baldwin et al. (1991) reported no differences across bullying. However, Mangus et al. (1998) found that sexual-based harassment occurs more frequently for women then it does for men. This was further supported by Ahmer et al. (2008) which found male students were more likely to be bullied by senior physicians and female students were more likely to report being bullied by other sources. However, across the studies, respondents indicated that perpetrators of bullying behaviors were found across the professional spectrum and included peers, faculty members, staff members, interns/residents, nurses, and other health care professionals. Although some of the studies examined demographic differences, examining how the experience of bullying varies across social identities is an area that requires further investigation.

Discussion

The results of this literature review highlight a prevalence of bullying behaviors that are directed toward medical students. Prevalence of bullying is not country specific as it has been shown to occur in Canada, New Zealand, Pakistan, and Saudi Arabia. This is in line with studies that have examined bullying in medicine more broadly (e.g., Klingberg et al., 2018; Lau et al., 2017). The majority of studies report that nearly half of the medical students surveyed, experienced some form of harassment in their training, most commonly by peers or senior physicians. Additionally, it was found the prevalence of this exposure was stable when

demographics (e.g., sex, race) were examined for differences except in the case of sexual harassment which was found to be experienced more by females rather than males. Based on the results of this literature review, it is clear that students are exposed to bullying and incivility while enrolled in medical school.

Research has highlighted the negative ramifications of bullying in medicine and this includes negative patient outcomes (Anderson 2013; Lachman, 2014), mental health issues including depression and suicidal ideation, and increased numbers of physicians electing to leave the field of medicine (Frank et al., 2006). In some health care centers, bullying is normalized and accepted. In order to understand how bullying behavior becomes normalized and adopted, it is important to understand when individuals are exposed to the behavior and what mechanisms result in the individual accepting incivility. Social learning and professional identify formation theories help to explain how medical students learn about professional standards from senior physicians and it is possible to hypothesize that this acclimation to incivility begins early on in their careers. In order to create shifts in the culture of bullying found in medicine, it is important to examine the learning processes that occurs for medical students.

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