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Differences in abuse of female and male medical students

The article "Differences in abuse reported by female and male Canadian medical students" (*Can Med Assoc J* 1994; 150: 357–363), by Dr. Rebeka Moscarello and associates, provided startling data to which the authors paid little attention. They seemed more concerned that the self-worth and satisfaction of students, especially female students, were reduced than that students were abusing patients and others in the health care system. According to the data in the article 53% (183/347) of the students acknowledged abusing others (peers, junior medical students, nurses, patients or patients' families and support staff). But, more important, 14% (33/230) of the male students and 16% (19/117) of the female students admitted they had abused patients. Although more female than male medical students reported being abusive to their patients, the difference was not statistically significant.

There are two possible conclusions: the definition of abuse used was so broad and all-encompassing that the term was trivialized, or something is seriously wrong with our medical education that so much abuse of others, including patients, takes place in a teaching hospital. If the first conclusion is correct, one wonders what motive lies behind efforts to sensitize students to abuse and to blame peers, faculty and clinicians (who, the report implies, are predominantly male). If the second conclusion is true, safeguards are needed to protect patients from abuse, and the issue of sex differences must not cloud the problem because, in this instance, women are as abusive as men.

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[One of the authors responds:]

Dr. Dineen's comment that "although more female than male medical students reported being abusive to their patients, the difference was not statistically significant" misrepresents the data. We compared male students who reported experiences of abuse during training with those who denied any such experiences, and then we examined the percentage of men in these two categories who reported that they had mistreated patients. A similar comparison was made for female medical students. Our data showed that there was a propensity for men to perpetuate their experience of abuse by abusing others, whereas men who had not been abused during training were not abusive. This propensity was not shown for women. In a separate article Margittai, Rossi and I[1] reported that all students who had experienced some form of abuse during training tended to perpetuate this mistreatment by abusing patients (20% [50/245]), whereas their peers who had not suffered abuse were much less likely to abuse patients (2% [2/102]; $\chi^2 = 19.24$, 1 df, $p < 0.001$). When similar comparisons were made for students who experienced abuse during medical training only (those who had experienced abuse before entering medical school were excluded) the results showed the same pattern. Of the male students 15% (14/95) perpetuated the abuse ($\chi^2 = 7.2$, 1 df, $p < 0.0007$), and of the female students 11% (4/35) had done so ($\chi^2 = 0.080$, 1 df, $p > 0.776$).

The conclusion that the definition of abuse used in our article is too broad and all-encompassing is a comment frequently made by those who deny the existence of violence against women and children in our society. Many academics and clinicians feel that such violence continues to be a major concern.[2] Our definitions of verbal, emotional and physical abuse were based on definitions used in previous studies published in reputable, peer-reviewed journals;[3,4] the definition of sexual harassment was based on those used by the Ontario Human Rights Commission[5] and the University of Toronto sexual harassment office.[6] Many people agree with Dineen that the definitions used by these agencies are too broad.

Determination of whether "something is seriously wrong with our medical education" was the purpose of our survey. Medical-school faculty members are also members of society, subject to social, racial and cultural attitudes toward women, minorities and those of lesser power. However, the fiduciary relationship between teacher and medical student, in which the teacher accepts the trust and confidence of his or her student to act in the best interest of that student, must prevail. The teacher–student relationship is one model for the physician–patient relationship.

Safeguards and policies are in place, and attitudes are changing. On Mar. 18, 1994, Dr. Arnie Aberman, the Dean of the University of Toronto Faculty of Medicine, issued a statement that "our faculty provides a working and learning environment that allows all of our staff and students to realize their full potential unimpeded by harassment or discrimination."[7]

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