was forty years old, the offspring of a family in which there had never been a physician, when I was offered admission to medical school. Since I was interested in making a career change, I accepted the admission offer eagerly. During the last few weeks of the summer before starting classes, I read several books about the medical school experience. They included tales of hardships suffered by M.D. students. After I graduated, I was asked by acquaintances whether medical school was as difficult as all that. I replied that what I experienced was as bad as any of the accounts I had read.

Some of the worst nightmares I had while in medical school concerned a twenty-five-year-old Chinese American classmate I will call Young Lee. I met Lee in 1993 at the outset of two years of M.D. study, which I undertook at an institution I will call Infirmity State University.

Lee couldn’t always be counted on to act as a reliable member of a team. Although holding his own academically, he soon was at odds with other students, myself included, because of his eccentric talk and behavior, including occasional outbursts of profanity. However, he was never overtly threatening to anyone. I thought his problem was merely immaturity. But the school administration decided otherwise. When one day, unwitnessed by any third party, he and another classmate got into a heated verbal altercation. Apparently there were some in the class who felt that Lee had made a pest of himself long enough. The upshot was that the classmate called the police alleging that, in her presence, Lee had tried to commit suicide by jumping from the second-floor student lounge window.

Lee denied the accusation. If, myself, don’t think it was credible on its face. The school authorities, however, siding with his accuser, offered Lee a choice of seeing a psychiatrist or being arrested. As soon as the hapless Lee submitted to the former, he was suspended, not on academic grounds—Lee was passing his classes, but on the grounds of alleged mental instability. The Catch-22 character of this incident left me shaken. Later, I obtained a pamphlet published by the American Medical Student Association entitled “Staying in Medical School: Understanding Your Student Rights.” I learned that what had occurred was not so unusual. Pressuring a student to see a psychiatrist of the school’s choosing as a condition of continuing M.D. study not only has been a time-honored tactic in medical education for winnowing a class but has been used with disproportionate frequency against students who belong to ethnic and racial minorities.

The Young Lee incident was the first hint I had of the extremes of student abuse in U.S. medical schools. Legislation exists in most states to limit abuse against doctors who serve as hospital residents, and while such legislation has not eliminated all abuses, it has addressed some of the worst mistreatment which was once a fact of daily life. But the problem of medical student abuse—the mistreatment of students working toward the M.D. degree—has not yet been addressed by comparable legislation. Since published documentation is limited to a few technical scholarly sources, the public is mostly unaware of medical student abuse. Like sexual assault, it is a secret topic, rarely publicized by its victims, with the result that its actual magnitude is hard to evaluate. Nevertheless, it takes a variety of forms, and no medical school is immune.

Why does abuse occur? According to my experience, medical school administrators and faculty members justify abusive practices by stating that they are merely challenging students appropriately to prepare them for the role they must play later as hospital residents—"happy slaves," as one hospital department chair once commented in sharing his conception of ideal residents. M.D. students, for their part, have invested so much financially, emotionally, and personally in medical school that they are loath to complain and risk dismissal. After all, what is the next step in life for the failed would-be doctor? And so the abuse goes on.

The documented effects of such abuse include depression, alcoholism, disparaging or giving up on the profession, ignoring the emotional needs of patients, and repeating the pattern of abuse toward students and others. It also interferes with learning, as well as the cultivation of a healthy philosophy of living and of maintaining relationships to one’s fellow human beings. According to my experience, abuses perpetrated on M.D. students fall into three broad categories: physical abuse, psychological abuse, and withholding learning opportunities.

**Physical Abuse**

One instance of physical abuse cited in the Journal of the American Medical Association (1990) concerns a student who was kicked in the genitals by a supervising doctor as punishment for making an error. The result was that the student required medical attention for his injuries. Although I have not seen an instance of kicking, I have observed assaults by doctors and nurses ranging from slapping the hands of a student who is...
Psychological Abuse

When I complained to the dean about mistreatment while studying obstetrics/gynecology, I was quickly served notice to appear before the Committee on Student Scholastic Standing for alleged unsatisfactory performance.

For instance, at Morbidity State, there was no committee on teacher-learner relations nor a medical school ombuds to whom students could appeal incidents of mistreatment. When I complained to the dean about mistreatment while studying obstetrics/gynecology in 1995, I was quickly served notice to appear before the school's Committee on Student Scholastic Standing for alleged unsatisfactory performance in that course. This occurred just a few days after the department concerned had already assigned me a passing grade.

Psychological abuse can also take the form of sniping or inappropriate comments on the student's appearance, physical attributes, or other nonperformance-related characteristics, either communicated verbally to the student or, worse, set down permanently in the student's academic record. For example, at different times in medical school, I've been informed by a faculty member that I am "fat." I've also been asked by a dean why I don't wear a wedding ring: "Are you really married to that man you've been parading around here as your husband?" I've been criticized by a course director for wearing hairbows to work because "it makes you look like a package." And it was once written in my course evaluation that I had "problems with personal hygiene"—this after I had come to every single lecture directly from a swim and shower at the nearby campus pool.

Another and more subtle kind of abuse is the practice of evaluating students in the same course by different standards, depending on whether they profess an interest in the supervising physician's specialty. If this were to happen in a nonmedical school setting, the comparable practice would be for, say, a lecturer of a calculus course to grade students by different standards depending on the subject in which they majored; that is, a score of 80 percent might be a B or an A depending on whether one majored in math or English.

Many students don't commit to a choice of specialty until the fourth and last year of their M.D. training. Nevertheless, it's common for course directors and attendings to ask younger students about their specialty interests. Often, in an effort to flattering the questioner, the student, out of naiveté, will express an interest in the supervisor's own specialty. In turn, the supervisor may decide to evaluate that student by a harsher standard than others, on the grounds that there's a self-styled "obligation" to that specialty to be careful as to who is going to be allowed to train for a career in it.

I've also known several physicians who have acknowledged that they engage in this inequitable practice, without appearing to see anything objectionable about it. They lose sight of the fact that the third year of the M.D. curriculum is a time for experimentation and trying possibilities. Using the gradebook to punish students for hypothesis testing and daydreams, as they do, is unreasonable.
Withholding Learning Opportunities

This is the most serious form of medical student abuse because it interferes with the acquisition of the professional expertise that patients expect in physicians. In many cases, it occurs by omission rather than commission. Attending physicians and residents, whose duties include teaching M.D. students, are rarely professional educators. Medical schools and teaching hospitals owe them training in appropriate teaching methods, but few facilities take this obligation seriously. The result is that M.D. instructors rarely are taught how to teach.

One of the most common ways in which this plays out is the tendency of attending doctors and residents to select one student to whom learning opportunities are offered to the exclusion of the other students in the group. The usual choice is the tallest or the most physically attractive male—the one who has the closest appearance to a stereotypic good-looking, confident young doctor. Both male and female attendings and residents are equally prone to showing such favoritism.

During an internal medicine rotation at Morbidity State, I noticed that more patients were being assigned to an attractive male in the group. Eventually, taking the risks into consideration, I told the female supervising resident that I was not being assigned enough patients. She replied that both students were admitting equal numbers, to which I rebutted, “I have kept count and so far he’s admitted seven while I’ve admitted only three.” The resident looked surprised and assured me that, if this was occurring, it was not happening deliberately.

In all educational settings, from kindergarten onwards, inexperienced instructors tend to practice unconscious favoritism, unless trained to educate equitably. The problem is that no one supervises medical educators day to day to assure that they educate students effectively. For their part, the students usually prefer to suffer from learning inequities rather than make an issue of them and face retaliation.

The failure to provide equal learning opportunities leads to discrepancies in performance. Another study in the Journal of the American Medical Association (1994) documented that women M.D. students perform inferiorly to men on national board examinations and that this inferior performance cannot be explained by any discrepancy in academic performance prior to medical school admission. The authors of the study profess to be puzzled by and unable to explain the discrepancy in male and female scores. However, they fail to entertain, even in passing, the possibility that there may be a discrepancy in training opportunities for men and women after they are inside the doors of the medical school.

Withholding learning opportunities also takes place in medical school by commission, not just by omission. For example, when I was summoned to appear before a school committee for alleged unsatisfactory performance in my OB-GYN course, I had just submitted to the dean a written complaint protesting the fact that, as the only woman among five students at that site, I alone was excluded from the opportunity to practice speculum examinations with PAP smears. Such examinations are an indispensable part of routine medical care for every post-pubescent woman and, needless to say, every doctor should be trained in the procedure. But the course director frankly informed me that he did not assign women students to the site where training in the examinations was offered. It’s interesting that I, not he, was charged by the school with unsatisfactory course performance after I complained to the dean about the discrimination. (The charges against me were eventually dropped when the course director failed to appear at any of the committee’s hearings on the case.)

Before embarking on medical study, I had a career in college teaching. If, as a professor, I had treated my students the way I was treated as an M.D. student, I would have been quickly summoned before my department chair or dean to account for myself. However, according to my experience, neither federal civil rights authorities nor physicians’ associations, such as the American Medical Association, take much interest in medical student abuse. During my medical school career, I contacted both the U.S. Civil Rights Commission as well as the AMA about the most severe of my experiences. The government refused to pursue a grievance on my behalf because I supposedly did not represent a “class action” case. The AMA’s student section officer replied that the organization did not have the authority to regulate medical schools’ treatment of students, notwithstanding that medical school accreditation is an AMA function.

Medical school administrations are rarely challenged by authorities for mistreating students, and schools have long shown themselves unwilling to clean house. The problem, as I see it, lies with the institutional and governmental nonenforce-