# Medical Students as Child Abusers

J. Martin Kaplan, MD

**Medical students may abuse pediatric patients. Not only do such students represent a hazard to the patient, but they may themselves be seriously ill and in need of psychiatric treatment.**

During the past decade, we have learned that the manifestations of child abuse are varied and include the battered infant as well as the child who is emotionally deprived. Many people, in addition to the parents, may be guilty of harming children. Siblings, family friends, and baby sitters are all potential perpetrators.[1-3] One person that would not normally be considered a potential offender is a physician or a physician in training. Unfortunately, experience over a period of nine years has indicated that there are medical students who have physically and/or emotionally harmed children on an inpatient service.

This report describes the episode of abuse, examines the character of the students involved, and suggests an approach to dealing with the problem.

## Medical Students

Student A is a 25-year-old male who selected a six-week clinical pediatric rotation during his senior year. His performance during the course was marked by inattentiveness and lack of cooperation with residents. He failed to write notes on his patients or order appropriate laboratory tests. The house staff refused to entrust patients to his care. During the last week of the assignment, his performance deteriorated. In attempting to obtain capillary blood from a child with leukemia, he repeatedly punctured the patient's fingertip until it was severely macerated. A nurse restrained him from making further attempts to obtain blood.

On another occasion, the student told a patient in the presence of her friends that a psychiatric consultation was being ordered for her. He had not consulted with the attending physician to determine whether the latter desired the consultation. While explaining to a third child in the presence of her friends the technique for collection of a 24-hour urine specimen, the student told the 12-year-old girl to "Piss in a jar." I spoke with the student and was surprised that he did not consider his behavior inappropriate or have any regrets for his actions. He received a failing grade for the course and was dropped from the rolls of the school.

During the next two years, he taught in the public school system and received psychiatric treatment. He then applied for and received permission to reenter

Dr. Kaplan is affiliated with the Department of Pediatrics, Hahnemann University, Philadelphia, PA.

medical school with the requirement that he repeat the third and fourth years. He had no difficulties with the didactic lectures, conferences, and examinations of the junior year. Upon entering the senior year his difficulties returned. His behavior and affect ranged from "boisterous and immature" to withdrawn, quiet, and uncertain. He was asked to leave medical school and has not applied for reentrance.

Because of the unfortunate outcome of his matriculation in medical school, his prior record was reviewed and is summarized below.

Student A was 22 years old when he entered medical school. He graduated from a highly regarded undergraduate college in the upper third of his class. He did well on his Medical College Admission Test (MCAT) and scored 755 of a possible 800 in Quantitative Ability. On his interview for admission, he was described as "neat, well-dressed, good appearance." The interviewer, an experienced member of the faculty, recommended "admission of this student with confidence."

During his first year in medical school, the student satisfactorily completed all required courses. However, he received adverse comments about his appearance and his ability to work with others. He entered the sophomore year, which then consisted of assignments to each of the major clinical sciences. Almost every evaluation noted his unkempt appearance, unusual affect, and lack of ability to acquire and effectively use information. Nevertheless, he managed to pass every course. The third year, a correlation of basic and clinical sciences was taught mainly in the classroom and was accomplished without apparent difficulty. The fourth year of the program then in place consisted of eight clinical rotations. Problems surfaced in every course. His knowledge and emotional stability were constantly questioned. His performance was sufficiently poor that he was required to repeat the senior year. During the repetition of the year, he took and passed the first two courses, radiation oncology and internal medicine. He then entered senior pediatrics with the results noted above.

Student B is a 28-year-old male. He took his first pediatric rotation during his sophomore year, in accordance with the curriculum in place at that time. His behavior was immediately noted to be unusual. He did not introduce himself to his assigned patients and ignored the children. His dress was inappropriately casual. He was often noted to be talking to himself and seemed unconscious of his surroundings. While on night call, he was often found at the nurses' station acting in an unusual manner. On one occasion, he told an adolescent with diabetes that she could eat food that both he and the patient knew were prohibited in her diet.

One evening, a mentally retarded child playfully tapped the student on his shoulder. The young man turned and hit the child with sufficient force to cause the patient's lip to bleed. When the student was told the child meant no harm, he replied, "Kids ought to be taught a lesson" and added that the child was lucky in that he knew judo and could really have injured the child if he had wished to do so.

The student was asked to undergo psychiatric evaluation. The psychiatrist reported that the student was an angry person with unresolved conflicts, but no evidence of psychotic behavior. The student expressed no remorse for his actions and was dropped from school. The bursar received a threatening letter from the student, but no harm to any school employee occurred.

Following these events, his prior record was reviewed and it was noted that the student had been in the Army for several years before attending college, where he achieved a 3.73 grade point average. His letter of recommendation from college was excellent and his MCAT score was superior. His interview for medical school was also favorable. He was considered to be "serious" and was given an "above average" evaluation. A clue to his character may be found in his correspondence with the admissions committee. In a letter of explanation for not taking a particular course, he wrote, "Concerning the apparent missing course in Organic Chemistry, son of a gun, nobody else caught that . . ., oh, well."

He passed all his freshman courses, but had academic difficulties in several subjects. One instructor noted him to be sleeping during conferences.

He began his second year by failing a surgery clerkship. Besides failing the final examination, he was noted to have "inappropriate interpersonal relationships."

Student C is a 26-year-old male who began his sophomore year with an obstetrics assignment, which he passed without difficulty. His second course was pediatrics. Three weeks into the rotation, a parent requested that the student not be permitted to care for her child with cystic fibrosis. When the parent was questioned as to her reasons, she stated that the student acted "in a rude and bizarre manner." The mother felt that she and her daughter had been "grilled" by the student during the taking of the history. Statements made by him during the initial interview included, "As a doctor, I see that you are going to answer all the questions evasively and ambiguously" and "I see that I tricked you with that question." Although the student had not as yet been counseled, he sought out the patient's mother and apologized to her with the statement, "I was tricked by my superiors." The parent remained upset, but realized the student was having emotional difficulties. During the same period of time, he had been observed correcting nurses' notes for grammar and spelling.

Because of this inappropriate behavior, I interviewed the student and found him to be extremely agitated and unable to remain still. His speech was tangential and inappropriate. He spoke of hearing voices that told him to do various things. The student underwent psychiatric evaluation. A diagnosis of schizophrenia was made and inpatient treatment was begun.

One year later, he returned to medical school. His first course was psychiatry, which he failed. He then began his pediatric rotation. His work was academically unacceptable. The student failed the final examination and then withdrew from school.

A review of his background indicated that he graduated from a large urban high school, where his scholastic record was excellent. He applied for entrance to a program which included two years in college and four in medical school. An interview conducted by a faculty member found him to be a person who "made a generally favorable impression." Another faculty member recommended him "without reservation." During his first two years of college, his overall grade point average was 3.9, with a science average of 3.8. He did not take the MCAT. During his first year of medical school, he passed all of his courses, but failed two examinations and barely passed several others.

## Discussion

The behavior of the first two students was marked by the fact that each had little or no awareness that they had injured a child. It is not unusual to see an overly aggressive medical student or a junior resident traumatize a child by repeated attempts to obtain blood or start an intravenous infusion. On one occasion, I have seen a house officer strike a child who pulled out a recently placed heparin lock. In this instance, the resident felt considerable remorse for several days and apologized profusely to the patient, parents, and attending physicians. Student A felt that he had not done anything inappropriate. The second student believed that a mentally retarded child deserved punishment for any action that the student considered to be wrong. The third student suffered a psychotic break during the assignment to pediatrics and was sufficiently ill that he could not fully appreciate the harm that had been done.

During the 10 years in which these cases came to my attention, no similar occurrences on services other than pediatrics have been known to me or to the faculty members occupying similar roles in medicine, surgery, obstetrics, gynecology, or psychiatry. Does this imply that patient abuse is more likely to occur on a pediatric service? Perhaps this is so. There are suggestions that children may be the object of beatings because some adults view them as not having equal rights. Older people may feel it is their duty to punish a young person for the juvenile's own good.[4-8]

Another reason that abuse is noted on a pediatric service is that our nurses and residents, working on a designated unit, become particularly attuned to a student's attitude toward his patients. Unusual actions may be detected more readily than they would be on an adult service. Whether the student's emotional problems may have been accentuated by contact with children is uncertain.

Do the actions of these three students reveal defects in the medical student selection process? All three students did well in their undergraduate studies and had excellent letters of recommendation. Student B had written a bizarre letter to the registrar, which was probably not seen by the admissions committee. The three students were in attendance during a period when approximately 1,200 others were admitted and graduated without other incidents of child abuse.

Were there any clues as to these stu-

dents' unprofessional conduct to be found in the records of their freshman year? Each did have problems in the first year. Student A was consistently evaluated as having below average knowledge, but he did not fail any examinations. His appearance and interpersonal relations were regarded as "borderline" by two of his preclinical instructors. In retrospect, the reports of unusual conduct and dress could have signaled an alert faculty member to speak with this young man and to realize that Student A was having problems that required psychiatric intervention. The second student failed several examinations during his freshman year, but there were no references to problems in dealing with others. Student C failed two examinations and was borderline in others. Again, there were no references to any character problems. Each of these students came from an undergraduate milieu, in which they were at the top of the class, to a medical school, in which they were barely getting by. Besides the disappointment and fear associated with the test failure, the reversal of their class standing added extra weight to their stress. If there are underlying problems, the stress of medical school can increase the symptoms.

The abuse of children by student physicians is not unique to any one school. I have observed such episodes at three of the five medical schools with which I have been associated.

There is little written about the appropriate course for the program director to take when he discovers behavior as described above. As in other instances of abuse, the physician should talk with the people concerned, i.e., the child, his/her parents, the medical personnel acquainted with the student's behavior, and the student himself. If the evidence points to abuse, this should be discussed with the student to ascertain his attitude toward the observed behavior. If his feelings are appropriate, i.e., remorse, desire to apologize, the trainee can be given a sufficient warning. The dean should be provided with a summary of the facts and the student's actions observed during the remainder of his time in medical school.

If the student's responses are inappropriate, he should be relieved of his responsibilities and consultation with a psychiatrist should be made mandatory if the student wishes to remain in school. Whether the student should be permitted to return to school, and under what circumstances, can be considered by a school's promotion or admissions committee or other appropriate mechanism.

## Summary

The unpleasant topic of child abuse was evaded for many years because physicians found it difficult to accept the fact that parents would purposely harm their children. In the past decade, it has become obvious that other adults, siblings, babysitters, etc., may also be perpetrators. Unfortunately, medical students must also be added to this list. Patients have a right to expect help and comfort from their physicians. If doctors in training willfully harm their patients, they may be seriously ill. Their continued participation in patient care must be reviewed and appropriate action

taken, if the behavior is not amenable to treatment.

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