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INTIMIDATION, HARASSMENT AND DISCRIMINATION IN INTERNSHIP AND RESIDENCY TRAINING IN A TEACHING HOSPITAL IN SOUTH-WEST NIGERIA

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ABSTRACT

Introduction: Intimidation, harassment and discrimination (IHD) occur in all organizations with higher proportion of the experience in the health care establishments without the exception of medical profession. Evidence from the studies in different part of the world showed that 42% to 93% of different cadres of medical profession have been victims. The study was undertaken to assess the pattern as well as the determinants of intimidation, harassment and discrimination among interns and residents in LAUTECH Teaching Hospital Ogbomoso, Nigeria. **Methodology:** A descriptive cross sectional design was used and all the 82 interns and resident doctors at all departments at the time of this study were included. A self administered semi-structured questionnaire was used to collect data and Statistical Package for Social Sciences (SPSS) version 17 was used for the analysis. Level of significant was set at 5% for the bivariate data analysis. **Results:** A total of 27 (32.9%) doctors reported that they had experienced IHD in the last 6 months even though almost all respondents, 77 (93.9%) reported to have experienced it at one time or the other in the past. The type of IHD experienced last ranged from verbal abuse (56.1%), humiliation (15.9%), deprivation of right such as leave (12.2%) and others. The primary basis for IHD was perceived to be hierarchical attitude (73.2%), followed by personal dislike (13.4%) and religion (6.1%). It was observed that there was statistically significant association regarding specialty (p=0.048), level of training (p=0.036) and years spent in training (p=0.034) whereas there was no significant association with respect to gender (p=0.741), age (p=0.521) and marital status (p=0.239). **Conclusion:** It is hoped that the identification of the prevalence and types of IHD and its related factors as well as of its critical effects on the interns, residents and patients health will allow developing intervention strategies and management of this phenomenon in the course of training specialists in Nigeria.

KEYWORDS: Intimidation, Harassment, Discrimination, Medical- Internship, Residency Training.

INTRODUCTION

Intimidation, harassment and discrimination occur in all organizations; although the proportion appears higher in health care establishments, the medical profession is no exception to this experience as shown by various studies carried out in different parts of the world.[1-3] Among various medical professionals who have reported abuse, those who are in the early phase of their careers, such as interns, are the most vulnerable.[2] According to Coverdae et al, the most common degrading experiences for interns were threats, intimidation, humiliation, excessive criticism, innuendo, exclusion or denial of access to opportunity and discrimination.[3] Federation des Medicins Residents du Quebec in a related publication reported that psychological harassment and intimidation regrettably remain present in our postgraduate training sites. Psychological harassment is defined on one hand by the instigators' actions (insults, threats, blackmail, restrictions, stigmatization, violence etc) and on the other hand on the effect on the victim (stress, isolation, distress, etc). These behaviours can have a negative impact on the person's psychological stability and mental health, his career choice and whether he continues with his career. It is also said to diminish his work satisfaction and ultimately jeopardise the patient care.[4,9]

Intimidation is defined as an intentional behaviour to make timid or fearful while harassment is a form of abuse in which there is purposeful disturbance of an individual causing instability and alienation of peace. Discrimination is the prejudicial treatment of an individual based on some reasons. It is the practice of unfairly treating a person or group of people.[6]

Several studies have quantified mistreatment among medical trainees or those on the lower ladder of a medical career. Daugherty et al reported in a national survey in the USA that about 93% of medical trainees had experienced at least one episode of mistreatment.[10] Another survey undertaken in the UK reported that around 84% of medical trainees had been bullied and about 69% had witnessed bullying and harassment during their Clinical placements.[11] It is reported that in medical school, 42% of students say they were victims of harassment, and 84% of intimidation. Heterogeneous studies report a similar trend among residents: from 45% to 50% of Canadian medical residents say they have been victims of harassment, intimidation or maltreatment in various forms during residency, compared with 91% of Japanese residents*. The sources of these abuses include supervising physicians, nurses, colleagues and patients. Certain rotations in general surgery (28%), internal medicine (21%), emergency medicine (12%) and anaesthesiology (11%) are among the sites most frequently mentioned.[2]

Schuchert et al have shown a significant relationship between verbal abuse during medical training and lower levels of confidence, regardless of sex, race, age or levels of ability and temperament.[12] Richman et al studied the mental health impacts for trainees who were subjected to maltreatment.[13] There appeared to be disconcerting tendencies for trainees suffering maltreatment to have 'psychopathological outcomes' in the forms of unrelenting affective emotions, resorting to 'self-medication' and dependency on mind altering substances.[14, 15] This is consistent with well-known observations that there are high levels of stress and psychological distress among medical trainees,[16] which have also been suggested as playing a role in the high rate of suicides among physicians.[17,18] There is also an indication that medical trainees who were most distressed at the beginning of their training were likely to report continuing stress and distress in the subsequent course of their lives.[19] According to Miedema et al, there are inherent mechanisms that perpetuate abusive behaviour in the medical culture, including working in what is perceived as a stressful environment.[20] This allusion to a view that 'abuse begets abuse' might imply the presence of a cycle of bullying within the medical profession.[21]

With the robust evidence of adverse experiences among medical interns and trainees in other parts of the world, and paucity of data of such in Nigeria, this study was done to increase the knowledge on level of Intimidation, Harassment and discrimination in Nigeria Tertiary Hospitals and make recommendations on postgraduate medical training in Nigeria. We also hope that it would help open up any unrecognized or neglected effect of abuse in medical profession and be a platform for mentorship in medical profession.

This study aims to assess the pattern as well as the determinants of intimidation, harassment and discrimination among interns and residents in LAUTECH Teaching Hospital (LTH) Ogbomoso.

METHODOLOGY

Study site

The study will be carried out in the Ladoke Akintola University of Technology Teaching Hospital, Ogbomoso, Oyo state. The Teaching hospital was established in 2011 to enhance health care delivery in Nigeria. It is located along Ilorin-Ogbomoso road. The resident and the intern doctors in addition to having direct relationship with consultants do relate with hospital staff, patients and their relatives, hospital visitors and other students such as the medical, Nursing and the laboratory science students. The Teaching hospital consists of residence on various programmes such as internal medicine. Community medicine, obstetrics and gynaecology, family medicine, surgery, Ear, Nose and Throat, Ophthalmology and Laboratory medicine.

Study population

The study population for this research was interns and resident doctors at all departments. All consenting interns and the residents were included in the study; sampling was not taken.

Study design

Descriptive cross sectional design was adopted for this study to assess the experience of intimidation, harassment and discrimination and their effects among the interns and resident doctors of the Ladoke Akintola University of Technology Teaching Hospital, Ogbomoso.

Inclusion and exclusion criteria

Residents who were supernumerary were included in the study but LTH residents on outside posting to other hospitals at the time of study as well as those on outside posting in LTH from other hospitals were excluded.

Instrument for data collection

A self administered semi-structured questionnaire was used for data collection. Information obtained included respondents' experienced of IHD, the situation and the sources and the effects on them. We also sought their opinion on how it could be prevented.

Data analysis

The data were checked for completeness and accuracy after which serial numbers were assigned to each for easy identification.

Open ended responses were coded using a guide developed for that purpose and data were entered onto the computer. Analysis was done using the Statistical Package for Social Sciences (SPSS) version 17.

Descriptive statistics and Chi-square test were used for bivariate data analysis at 5% level of significance.

Ethical consideration

Verbal informed consent was obtained from the participants and their confidentiality assured.

RESULTS

Eighty-two questionnaires were administered to the respondents and all the questionnaires were completed, giving a response rate of 100%.

Table 1 shows the socio-demographic characteristics of the respondents. There were more males than females (53; 64.6% and 29; 35.4% respectively. The mean age was 32.12 ± 4.82 years. Other socio-demographic data are as in Table 1.k.

Table 2 shows the frequency distribution of relationship of respondents with consultants and seniors (other than consultants).

Table 3 shows the prevalence, source, type and perceived reason for disrespect/ IHD. A total of 27 (32.9%) doctors reported that they had experienced IHD in the last 6 months even though almost all respondents, 77 (93.9%) reported to have experienced it at one time or the other in the past. Senior registrars and consultants represent 74 (90.3%) of the sources of IHD. Type of IHD experienced last ranged from verbal abuse (56.1%), humiliation (15.9%), deprivation of right such as leave (12.2%) and others. The primary basis for IHD was perceived to be hierarchical attitude (73.2%), followed by personal dislike (13.4%) and religion (6.1%). The effect of IHD on respondents range from demoralization (39.0%), de-motivation (26.8%), stress (31.7%) and a greater percent (41.5%) believe IHD had a helpful effect on them.

Table 4 above shows the relationship between socio-demographic characteristics and ever had IHD in the last six (6) months. There was statistically significant association regarding specialty, level of training and years spent in training whereas there was no significant association with respect to gender, age and marital status.

Table 1: Socio demographic characteristics of respondents

Variables	Frequency (n=82)	Percentage (%)
Gender		
Male	53	64.6
Female	29	35.4
Age Group		
20-29	21	25.6
30-39	55	67.1
>39	6	7.3
Marital Status		
Ever married	64	78.0
Never married	18	22.0
Spouse's Occupation (Married)*		
Lecturer/Teacher	17	20.7
Medical personnel	28	34.1
Civil servant	7	8.5
Accountant/Business man	12	14.6
Specialty		
Medicine	10	12.2
O and G	11	13.4
Lab Medicine	9	11.0
Pediatrics	8	9.8
Family Medicine	8	9.8
Community Medicine	10	12.2
Surgery	11	13.4
Intern	15	18.3
Level of Training		
Intern	15	18.3
Junior Resident	55	67.1
Senior Resident	12	14.6
Number of years in training		
1	49	59.8
2	22	26.8
3	11	13.4

*n = 64

Table 2: Frequency distribution of relationship of respondents with consultants and seniors (other than consultants)

Variable	Cordial & Close	Cordial not Close	Strictly Official	Hostile
Relationship with Consultants	26 (31.7)	37 (45.1)	17 (20.7)	2 (2.4)
Relationship with seniors (other than consultant)	43 (52.4)	28 (34.1)	11 (13.4)	0 (0.0)

Table 3: Prevalence, Source, Type and Perceived Reason for Disrespect / IHD

Variable	Frequency (n=82)	Percentage (%)
Ever had IHD in last 6months		
Yes	27	32.9
No	55	67.1
Ever been treated with Disrespect (IHD) by seniors		
Often	24	29.3
Occasionally	53	64.6
Never/Rarely	5	6.1
Usual **Source of Disrespect** /perceived **IHD**		
Consultant	61	74.4
Senior Registrar and above	13	15.9
Junior Registrar and above	3	3.7
None / No response	5	6.1
Type of IHD last **Experienced**		
Verbal abuse/Shouting at/Insult	46	56.1
Look down with contempt/Humiliate	13	15.9
Physical hit	2	2.4
Withholding of right- leave	10	12.2
Punish by giving academic /clinical assignment	6	7.3
No response	5	6.1
Perceived Reason for IHD		
Religion	5	6.1
Personal dislike	11	13.4
Hierarchical attitude	60	73.2
Others	1	1.2
No response	5	6.1
Perception of the effect of IHD (multiple responses)		
Demoralizing effect	32	39.0
De-motivating effect	22	26.8
Somewhat helpful effect	34	41.5
Stress effect	26	31.7
Others	2	2.4

Table 4: Relationship between socio-demographic characteristics and ever had IHD in the last 6 months.

Variable	Ever had IHD			
	Yes	No	Total	Statistical indices
Gender				
Male	**17**	**36**	**53**	**X^2 =0.109**
Female	**10**	**19**	**29**	**df = 1**
				p= 0.741
Age Group				
20-29	**9**	**12**	**21**	**X^2 = 1.305**
30-39	**16**	**39**	**55**	**df = 2**
>39	**2**	**4**	**6**	**p = 0.521**
Marital Status				
Ever married	19	45	64	X^2 = 1.385
Never married	8	10	18	df = 1
				p = 0.239
Specialty[$]				
Medical	12	33	45	X^2 = 6.095
Surgical	6	16	22	df = 2
Intern	9	6	15	p = 0.048
Level of Training				
Intern	9	6	15	X^2 = 6.633
Junior Resident	16	39	55	df = 2
Senior Resident	2	10	12	p = 0.036
No of yrs in training				
1	**20**	**29**	**49**	**X^2 = 6.735**
2	**7**	**15**	**22**	**df = 2**
3	**0**	**11**	**11**	**p = 0.034**

$ Specialty are categorized as (Medical = Internal Medicine, Paediatrics, Family Medicine, Community Medicine and Laboratory Medicine while Surgical = General and subspecialty Surgery including Ophthalmology, ENT, Radiology, Anaesthesia)
*p-values less than 0.05 are statistically significant

Table 5: Perception of respondents on how IHD can be prevented

How can IHD be prevented	Frequency	%
Litigation	18	22.0
Appeal by management, medical	36	43.9
Intervention of professional bodies	34	41.5
Training of Trainers	36	42.7
Others ways	20	24.4

DISCUSSION

Medical residents are challenged every day with myriads of academic requirements, job strain and patient safety concerns. Unfortunately, impediments to the educational process due to medical resident mistreatment by intimidation, harassment and discrimination (IHD) remain highly prevalent in training today. Medical trainee intimidation, harassment and discrimination is a widespread phenomenon and not a problem limited to certain countries or particular training programs[22]; with high levels being reported in Australia[23], Canada[1], India[24] and the USA[10] but with paucity of data about it in Subsahara/ West Afarica and Nigeria in particular. This study is one of the very few that had been carried out on this subject matter in this environment. The response rate in this study is unique compared to the experience of other authors in Nigeria[8], Canada[1], Mexico[25] and Oman[2] who reported 80.6%, 62.0%, 64.2% and 84.0% respectively.

Regarding the prevalence of IHD, more than half (64.6%) of the respondents claimed to have ever been treated with disrespect though occasionally while 29.3% were often treated with disrespect. In a similar study among the resident medical doctors in Canada more than seven in ten (72.9%) residents reported behaviour from others that made them feel diminished during their residency.[26] In another study in Iran, the authors reported that the prevalence of any type of abuse experienced was 89%; 43% of residents experienced verbal and physical threats, 10% physical assault and 31% sexual harassment.[27] This is a pointer to the fact that the problem of IHD is still prevalent and deserves the needed attention to arrest the trend.

The subject of IHD meant different thing to the instigator and the victim, according to the Federation des medicins residents du Quebec "Position Statement on medical resident health and wellness''[4] "Psychological harassment is defined on the one hand by the instigator's actions (insults, threats, blackmail, restrictions, stigmatization, violence, etc.) and on the other hand by the effect on the victim (stress, isolation, distress, etc.)". In this study the most recognized source of IHD is the consultants. This is similar to the findings in Canada among the family medicine residents[1] where the main sources of IHD were specialist physicians, hospital nurses, specialty residents and patients. This workplace attitude had led to a strain relationship between the consultants and medical residents; for instance in this study45.1% of the respondents submitted that they did not have cordial relationship with their consultants.

Type of IHD experienced in this study ranged from verbal abuse, humiliation, deprivation of right- leave, off duty - punishment by giving academic/clinical assignment and physical hit. This is consistent with the findings by other authors; in 2010, Alebiosu[8] mentioned that most reported forms of bullying are inappropriate comments, withdrawal of privileges or opportunities, imposition of punishment with more work and recrimination for reporting these incidents. A multicenter study conducted in Japan indicated that verbal abuse toward residents in the hospital environment is common and tends to be similar to that of other countries and cultures.[28]

The primary basis for IHD was perceived to be hierarchical attitude, followed by personal dislike and religion. In a similar study among the residents in Mexico factors related to bullying are gender, ethnicity and status of foreign students.[29] Gender, ethnicity and culture were related to IHD in the study among the family medicine residents in Canada.[1] This is an indication that IHD is a problem in developed and developing countries, likewise in any workplace where religion and cultural differences are allowed to becloud the "Hippocratic oath" of brotherliness in medical practice, the manifestation of IHD will be obvious. In this study, ever been treated with disrespect by seniors was not associated with gender, marital status, specialty and number of years in training.

Studies have found that main source of inappropriate behaviour, harassment and belittlement of physicians-in-training is from their fellow physicians in superior positions and hospitals have a particularly hierarchical foundation in which bullying can flourish.[2, 20] More broadly, the literature reveals that predominant perpetrators of mistreatment in medical education settings were consultants, supervisors, instructors, physicians, colleagues, nurses, allied health personnel and sometimes patients.[2] Succinctly, Leisy and Ahmad[30] describe the potential causes for resident

mistreatment to include hierarchy, silence, incognizance, fear, acceptance/denial and a legacy of abuse.

Such abuse during training creates hostile work environments and induces stress and discomfort, which may impair performance.[10] A study among the residents in Mexico linked IHD to the onset of symptoms such as loss of confidence, fatigue, depressive feelings and absenteeism[2] that negatively affect productivity and professional learning in academia.[31] Sheehan and colleagues found that trainees who were frequently harassed were less likely to complete assignments or provide optimal patient care.[32] The breakdown in effective communication secondary to bullying can lead to medical errors.[33]

Furthermore, trainees who were harassed had more emotional health problems and family life and social responsibility disruptions compared with non harassed trainees.[32] Other studies found that harassed trainees were more likely to have depression, anxiety, insomnia and appetite loss and were more likely to drink alcohol for escape than non harassed trainees.[14,15] One study showed that over 20% of residents would not pursue medicine again if given the chance to relive their career[5] and several would even advise others not to become physicians.[2] In actuality, residents most often experience anger, diminished eagerness to work, depression, increased feelings of difficulty at work, health problems and thoughts of dropping out in response to intimidation.[34]

This study is in consonant with what above authors reported; where the effect of IHD on respondents ranged from demoralization, de-motivation and stress. A study conducted among the nurses in public hospital in Ibadan, south-western Nigeria[35] established that job stress has significant effect on physical and mental health of the nurses. It also established that there was a significant difference' in personal and work behaviour of highly stressed nurses and less stressed nurses. IHD has a significant impact on the organization where it occurs, including an impact on productivity, financial costs and reputational costs.[36] In 2008, it was estimated that the financial cost of bullying and harassment to the National Health Service (NHS) was £325 million per annum.[37]

A good number of the participants in this study (41.5%) believed IHD has a helpful effect on them. This is similar to was reported by Leisy and Ahmad[30] where some have suggested that increased pressure and intimidation serves to sharpen a resident's skills or determination to be a physician and as such, is a rite of passage. However, survey-based research has shown that only 2% of medical doctors who experienced abuse agreed that it "increased eagerness and indomitable determination to learn medicine."[34]

Majority of the respondents in this study is of the opinion that IHD can neither be prevented by litigation nor appeal by management or medical council. The reason is not farfetched, supervisors are often the perpetrators of these behaviours and are in a superior position, which can intensify trainees' fear of negative consequences from reporting any form of abuse.[34] Thus, authorities must ensure trainees' confidentiality when reporting harassment or discrimination. Other reasons that may lead to the underreporting of harassment and discrimination include the fear of being disbelieved, embarrassment if peers learned of the occurrence and a lack of trust in those who are in positions of authority. Trainees also may think that these behaviours are a necessary part of becoming a physician. Therefore, education is imperative for all parties to understand what constitutes abusive and hostile behaviors.[22] Creation of committees for mediation and investigation of IHD reports have been recommended as a solution to IHD.[5,38]

This study has some identified limitations. First, a subjective tool, using self-report was used. Second, cross-sectional survey was used to assess the respondents' experiences of intimidation, harassment and discrimination, which often is open to recall bias. Third, some important variables (e.g., perpetrators' genders and why the instigation) were not identified. The issue of sexual harassment which was prominent in the IHD studies among the medical residents in Canada[1], Oman[2] and Lithuania[39], to mention a few was not addressed in this study.

In conclusion, this study leads us to reflect on the IHD of medical residents and interns which, despite being a relatively common phenomenon, should not be tolerated because of its critical effects on both the residents and patients health. It is hoped that the identification of the prevalence and types of IHD and its related factors will allow developing intervention strategies and management of this phenomenon in the course of training specialists in Nigeria. Further studies especially multi-centre that will include qualitative data, responses from tutors (consultants) are also needed.

REFERENCES

1. Crutcher RA, Szafran O, Woloschuk W, Chatur F, Hansen C. Family medicine graduates' perceptions of intimidation, harassment, and discrimination during residency training. BMC Med Educ, 2011; 11: 88.
2. Al-Shafaee M, Al-Kaabi Y, Al-Farsi Y, et al. Pilot study on prevalence of abuse and mistreatment during clinical internship: Across-section study among first year residents in Oman. BMJ Open, 2013; 3: e002076. doi:10.1136/bmjopen-2012-002076
3. Coverdale JH, Balon R, Roberts LW. Mistreatment of trainees: verbal abuse and other bullying behaviours. Acad Psychiatry, 2009; 33: 269–73.

4. Federation des medicins residents du Quebec ''Position Statement on medical resident health and wellness''. April 2013; 1-3.
5. Cohen JS, Scott P. Well-being in residency training: A survey examining residents' physician satisfaction both within and outside of residency training and mental health in Alberta. BMC Medical Education, 2005; 5: 21.
6. Online Webster Dictionary.
7. West African College of Surgeons Prospectus. College Secretariat Ibadan, Nigeria 1999.
8. Alebiosu OC, Ogunsemi OO, Shorunmu OT. A survey of perceived stress, intimidation, harassment and well-being of resident doctors in a Nigerian teaching hospital. Nigeria Journal of Clinical Practice June 2010; 13(2): 133-186.
9. Shizuko N, Tetsuhiro M, Misaki Y, Takuro S. Universal problem during residency: Abuse and harassment. Medical Education, June 2009; 43(7): 628-36.
10. Daugherty SR, Baldwin Jr DC, Rowley BD. Learning, satisfaction, and mistreatment during medical internship: a national survey of working conditions. J Am Med Assoc, 1998; 15: 1194–9.
11. Quine L. Workplace bullying in junior doctors: questionnaire survey. BMJ, 2002; 324: 878–9.
12. Schuchert MK. The relationship between verbal abuses of medical students and their confidence in their clinical abilities. Acad Med, 1998; 73: 907–9.
13. Richman JA, Rospendo KM, Nawyn SJ, et al. Sexual harassment and generalized work place abuse among university empoyees: Prevalence and mental health correlates. Am J Public Health, 1999; 89: 358-63.
14. Dyrbye LN, Thomas MR, Massie FS, et al. Burnout and suicidal ideation among U.S. medical students. Ann Intern Med, 2008; 149: 334–41.
15. Bhan A. Substance abuse among medical professionals: a way of coping with job dissatisfaction and adverse work environments. Indian J Med Sci., 2009; 63: 308–9.
16. Dyrbye LN, Thomas MR, Shanafelt TD. Medical student distress: causes, consequences, and proposed solutions. Mayo Clin Proc, 2005; 80: 1613–22.
17. Aasland OG, Hem E, Haldorsen T, et al. Mortality among Norwegian doctors 1960–2000. BMC Public Health, 2011; 11: 173.
18. Petersen MR, Burnett CA. The suicide mortality of working physicians and dentists. Occup Med (Lond), 2008; 58: 25–9.
19. Tartas M, Walkiewicz M, Majkowicz M, et al. Psychological factors determining success in a medical career: a 10-year longitudinal study. Med Teach, 2011; 33: e163–72.
20. Miedema B, MacIntyre L, Tatemichi S, et al. How the medical culture contributes to coworker-perpetrated harassment and abuse of family physicians. Ann Fam Med, 2012; 10: 111–17.
21. Al-Adawi S, Al-Bahlani S. Domestic violence: 'What's love got to do with it?' Sultan Qaboos Univ Med J, 2007; 7: 5–14.
22. Fnais N, Soobiah C, Chen MH, Lillie E, Perrier L, Tashkhandi M, Straus SE, Mamdani M, Al-Omran M, Tricco AC. Harassment and Discrimination in Medical Training: A Systematic Review and Meta-Analysis Academic Medicine, 2014; 89(5): 817-823.
23. Askew DA, Schluter PJ, Dick ML, Régo PM, Turner C, Wilkinson D. Bullying in the Australian medical workforce: cross-sectional data from an Australian e-Cohort study. Aust Health Rev., 2012; 36: 197–204.
24. Bairy KL, Thirumalaikolundusubramanian P, Sivagnanam G, Saraswathi S, Sachidananda A, Shalini A. Bullying among trainee doctors in Southern India: a questionnaire study. J Postgrad Med, 2007; 53: 87–90.
25. Ortiz-León S, Jaimes-Medrano AL, Tafoya-Ramos SA, Mujica-Amaya ML, Olmedo-Canchola VH, Carrasco-Rojas JA. Experiences of bullying in medical Residents. Cirugía y Cirujanos, 2014; 82(3): 249-259.
26. Karim S, Duchcherer M. Intimidation and harassment in residency: a review of the literature and results of the 2012 Canadian Association of Interns and Residents National Survey. Canadian Medical Education Journal, 2014; 5(1): e50-e53.
27. Sadrabad AZ, Bidarizerehpoosh F, Rad FR, Kariman H, Hatamabadi H, Alimohammadi H. Residents' Experiences of Abuse and Harassment in Emergency Departments. Journal of Interpersonal Violence, 2016; I-II. Available at jiv.sagepub.com.Accessed on 9/5/2017.
28. Scott J, Blanshard C, Child S. Workplace bullying of junior doctors: a cross-sectional questionnaire survey. N Z Med J. 2008; 121(1282): 10–4.
29. Hoosen AI, Callaghan R. A survey of workplace bullying of psychiatric trainees in the West Midlands. Psych Bull. 2004; 28(6): 225-227.
30. Leisy HB, Ahmad M. Altering workplace attitudes for resident education (A.W.A.R.E.): discovering solutions for medical resident bullying through literature review. BMC Medical Education, 2016; 16: 127.
31. Ogunsemi OO, Alebiosu OC, Shorunmu OT. A survey of perceived stress, intimidation, harassment and well-being of resident doctors in a Nigerian Teaching Hospital. Niger J Clin Pract, 2010; 13(2): 183-186.
32. Sheehan KH, Sheehan DV, White K, Leibowitz A, Baldwin DC Jr. A pilot study of medical student "abuse". Student perceptions of mistreatment and misconduct in medical school. JAMA. 1990; 263: 533–537.
33. Leape LL, Shore MF, Dienstag JL, Mayer RJ, Edgman-Levitan S, Meyer GS, et al. Perspective: a culture of respect, part 1: the nature and causes of disrespectful behavior by physicians. Acad Med. 2012; 87(7): 845–52.

34. Nagata-Kobayashi S, Maeno T, Yoshizu M, Shimbo T. Universal problems during residency: abuse and harassment. Med Educ. 2009; 43(7): 628–36.
35. Mojoyinola JK. Effects of job stress on health, personal and work behavior of nurses in public hospitals in Ibadan Metropolis, Nigeria. *Ethno-Medicine*, 2008; 2: 143-8.
36. Bartlett JE, Bartlett ME. Workplace bullying: an integrative literature review. Adv Develop Hum Resour, 2011; 13: 69–84.
37. Department of Health. Bullying of staff within the NHS. London: Department of Health; 2008.
38. Whiteside, D, Stubbs, B, Soundy. Physiotherapy students' experiences of bullying on clinical internships: A qualitative study. Physiotherapy, 2014; 100(1): 41-46.
39. Vagonis A, Geciene A, Steibliene V. Perception of sexual harassment experience during residency training: relation with gender, marital status, anxiety and depressive symptoms and quality of life. Biological psychiatry and psychomarcology, 2015; 17(2): 47-51.