

Medical Students' Experiences of Professional Lapses and Patient Rights Abuses in a South African Health Sciences Faculty

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Abstract

Purpose

To elicit South African medical students' experiences of witnessing patient rights abuses and professional lapses during their clinical training in order to inform an appropriate and effective response.

Method

During June and July 2009 at the University of Cape Town Faculty of Health Sciences, the authors surveyed 223 fourth-, fifth-, and sixth-year medical students in selected clinical rotations concerning abuses they had observed. Volunteers were later interviewed individually. The authors coded interview transcripts for key themes using a constant-comparative grounded theory approach.

Results

Of 223 students surveyed, 183 (82%) responded, 130 (71%) of whom reported witnessing patient rights abuses and professional lapses, including physical abuse (38%), verbal abuse (37%), disrespect for patients' dignity (25%), and inadequately informing patients about their treatment (25%). Students attributed abuse to stressed health workers, overburdened facilities, and disempowered patients. Most students who witnessed abuse (59%) did not actively respond, and 64% of survey respondents felt unprepared or uncertain about challenging abuses in the future. Interviews with 28 students yielded detailed accounts of the abuses

witnessed and of students' emotional reactions, coping strategies, and responses. Most students did not report abuses; they feared reprisal or doubted it would make a difference.

Conclusions

This study demonstrates the disjunction between what these students were taught about human rights and ethics and what they witnessed in clinical settings. The high prevalence of patient rights abuses experienced by these students highlights the need to align medical ethics and human rights with medico-legal protocols in theory and clinical practice.

In 1994, the University of Cape Town (UCT) Faculty of Health Sciences reformed its medical curriculum to meet the changing demands of a new national health system in a democratic South Africa.¹ The foundation of this system is the primary health care (PHC) approach with its concern for social justice,² which

is particularly relevant given South Africa's history of inequity and discrimination under apartheid. The reformed curriculum has placed greater emphasis on teaching about human rights and bioethics, and it recognizes professionalism as one of the core competencies for graduates.^{3,4}

Background

Caldicott and Faber-Langendoen⁵ have suggested that despite years of teaching and research on ethics in medical education, medical students "still lacked the tools to navigate ethical dilemmas effectively." One dilemma they described is the mismatch between what students are taught in the classroom and what they experience in clinical settings—more specifically, the meaning they attach to the practices they observe. Ginsburg and colleagues⁶ studied senior medical students' perceptions of professional lapses in an attempt to identify and resolve the discrepancy between the dilemmas students faced in the clinical setting and the medical profession's abstract definitions of professionalism. Their analysis identified six critical

issues—namely, communicative violation, role resistance, objectification of patients, accountability, physical harm, and crossfire.

Ginsburg and colleagues'⁶ analysis of perceived professional lapses can be applied to an investigation of how medical students perceive patient rights abuses in the South African clinical training setting. In describing the development of human rights competencies in South African health professional graduates, London and colleagues⁷ observed that teaching about human rights is viewed to be "political," confrontational, or "unnecessary to professional practice," leading to the stigmatization of such learning. They also observed that human rights are frequently sublimated within bioethics teaching because of the conflation of the two by curriculum developers and may be relegated to the "hidden curriculum" on the assumption that practitioners will role model a rights-based approach.⁷ The effect of this sublimation may be to disguise and even justify callous behavior in the mistaken belief that it inculcates resilience in students.^{8,9} This may lead to

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an erosion in student empathy during clinical training that may be exacerbated by a lack of role models, study and work pressures, and patient and environmental factors.¹⁰

How reliable role models are in teaching medical ethics depends on the clinical teaching context and the society at large. The South African context poses unique ethical challenges as a developing country with a history of legislated racial discrimination and stark socioeconomic inequities between most patients and their health care providers. Coovadia and colleagues¹¹ ascribe the nation's current public health challenges to "racial and gender discrimination, income inequalities, migrant labour, the destruction of family life, and persistent violence, among other factors."

Given this context, it is not surprising that, during clinical clerkships, medical students in the UCT Faculty of Health Sciences have long witnessed and reported on health care providers' unprofessional behavior and abuses of patient rights. Such student reports were noted in the minutes of the Faculty's Transformation and Equity Portfolio from 1998 through 2007 and in 2009 were the subject of a continuing education committee in the Division of Family Medicine. Patient rights abuses have continued because of the absence, among other things, of a clear mechanism for holding perpetrators accountable.

The purpose of this study was to elicit from medical students information about the patient rights abuses and professional lapses by health care providers that they witnessed and experienced during their clinical training, in order to inform an appropriate and effective response and to demonstrate the importance of professionalism education in clinical settings.

Method

Setting

The UCT Faculty of Health Sciences is located in Cape Town, South Africa, close to one of two tertiary teaching hospitals in the city. Like other South African medical schools, its medical degree (MBChB) program takes six years. The first three years are preclinical and are spent learning the basic medical sciences

and clinical laboratory (diagnostic) sciences. Years 4 through 6 are predominantly spent in clinical clerkships. Learning about health professionalism, as a core competency, has been integrated throughout the six years' curricula.¹² Bioethics and human rights are taught in a complementary manner and are integrated into theory and practice in the curriculum for years 1 to 3. These subjects are also taught in year 4 during the public health and general medicine rotations, as well as in year 6 in class sessions and weekly bedside ethics seminars.

The medical school has approximately 1,100 students across the six years of study. Each year, about 500 medical students in years 4 through 6 (165 per year of study) rotate in blocks of 40 through clinical clerkships in the tertiary hospital and a number of secondary or regional hospitals, primary care clinics, and midwife obstetric units (MOUs) in the metropolitan area.

Approximately 80% of students entering medical school in South Africa do so at age 18 or 19 after completing secondary school, but a small number of students have done some tertiary study. UCT has a policy of promoting equity within the student body by recruiting increasing numbers of students from previously disadvantaged black communities. Our student body's racial and ethnic composition is reflected in the demographics of the class that entered in 2011: 54% African autochthons, 18% multiracial (mixed descent), 14% white, 10% Indian, and 4% Chinese and other international students. The gender composition is 66% women and 34% men.

Ethics approval for this study was obtained from the UCT Faculty of Health Sciences human research ethics committee in May 2009.

Participants

In June and July 2009, we invited 223 fourth- through sixth-year students in selected clinical rotations to participate in a survey and optional individual interviews. These students were in fourth-year general medicine and psychiatry rotations ($n = 86$), fifth-year general medicine and neurology rotations ($n = 74$), and sixth-year general medicine and family medicine rotations ($n = 63$).

Survey and interviews

We used a written survey that students completed during class time. The survey consisted of 15 multiple-choice and open-ended questions about patient rights abuses they had witnessed during their clinical training, their opinions about the causes of the abuses, how they had responded to the abuses, and whether they felt prepared to challenge future abuses. Participation was voluntary, nonincentivized, and anonymous unless the participant was willing to be contacted for a follow-up interview and indicated this by providing his or her name and contact details on the survey. In mid-June through mid-August 2009, the principal author (L.V.), a medical anthropologist, conducted interviews with individual participants using a standard schedule. The interviews were audio-recorded and transcribed with the consent of the participant. Interviews lasted 10 to 33 minutes.

Data analysis

Survey data were entered into an Excel spreadsheet for analysis. Three authors (L.V., M.J.K., J.I.) independently analyzed and coded students' responses to the open-ended questions. We coded types of abuses according to the Patients' Rights Charter,¹³ and we listed responses to the other open-ended questions, examined them for similar meanings and interpretations, and consolidated them into categories (codes). We resolved any coding disagreements through discussion. One author (C.N.) checked all codes for consistency and completeness before they were entered into the spreadsheet.

The same author (C.N.) analyzed and coded the interview transcripts for key themes, primarily using a constant-comparative grounded theory approach. During the interviews, students elaborated on many of the issues raised in the survey, and, where relevant, the coding structure used for the survey data was applied to the interview data. In this way, the interview data were coded using a combination of top-down (guided by the survey coding structure) and bottom-up (grounded in the data) approaches. We developed broad categories (tree nodes) from the research questions and subcategories (free nodes) directly from the responses. We used NVivo version 2 qualitative data analysis software (QSR

International, Doncaster, Victoria, Australia) to apply the codes. The initial coding tree was rigorously examined and refined by L.V. and C.N. to ensure the validity of the tree nodes. Individual free nodes were assessed with respect to coder agreement about their meaning, relevance, and placement in the tree.

Results

Response rates

Survey. The overall survey response rate was 82% (183/223). Class response rates varied significantly: 100% (86/86) of fourth-year students, 85% (63/74) of fifth-year students, and 54% (34/63) of sixth-year students completed the survey. Among the 183 respondents, 102 (56%) were female, and the mean age was 23 years (range: 20–29 years). The ratio of responding students across years 4, 5, and 6 was 47%:34%:19%. Most respondents (164; 90%) were of South African nationality. Most (122; 67%) named English as their home language, followed by isiZulu (19; 10%), Setswana (11; 6%), isiXhosa (6; 3%), Sepedi (5; 3%), and French (4; 2%). We did not collect data concerning race or ethnicity.

Individual interviews. Twenty-eight (15%) of the 183 survey respondents provided their contact information, indicating they were interested in being interviewed. During the interviews, these students identified and described in detail the patient rights abuses they had witnessed. Among the 28 interviewees, 14 (50%) were female; 17 (61%) were fourth-year students, 10 (36%) were fifth-year students, and 1 (3%) was a sixth-year student.

Emergent themes

Five broad themes emerged from our analysis of students' responses to the interview research questions: abuses of patient rights, identity of perpetrators, student responses to abuse, medical education factors, and health systems issues. In the sections that follow, we report survey and interview results related to the first three themes, which are the focus of this article.

Nature and causes of abuses witnessed

Of the 183 survey respondents, 130 (71%) reported that they had witnessed patient rights abuses. Most commonly these 130 students reported observing

Table 1

Types of Patient Rights Abuses Witnessed During Clinical Rotations by 130 Fourth-, Fifth-, and Sixth-Year Medical Students, University of Cape Town Faculty of Health Sciences, 2009

Type of abuse witnessed	No. (%) of students*
Physical abuse	50 (38)
Verbal abuse	48 (37)
No respect for patient dignity	33 (25)
Inadequate health information provided to patient [†]	32 (25)
No confidentiality [†]	20 (15)
No informed consent [†]	15 (12)
Poor quality of care/neglect	15 (12)
Racial/ethnic/age discrimination	13 (10)
Care not timely [†]	12 (9)
Denied care	10 (8)
No patient participation in care decisions [†]	3 (2)

* Students were asked to mark on the survey all of the types of abuse they had witnessed; therefore, totals exceed 130 (100%).

[†] Professional lapse reported by students as a patient rights abuse.

physical abuse (50; 38%), verbal abuse (48; 37%), disrespect for patient dignity (33; 25%), and inadequate information provided to patients about their treatment (32; 25%) (Table 1). Students gave as examples the open discussion of patients at the bedside, lack of informed consent for procedures, patients left exposed after examination, no analgesia given during procedures, inappropriate "poking" of wounds, and patients left in a soiled state.

In the individual interviews, students most often described physical and verbal abuse (Figure 1), particularly in the MOUs, as typified by the following two incidents involving midwives and mothers in labor:

She was slapped probably about 15 to 20 times on all parts of her body.... She's stark naked giving birth ... and so they were trying to hold her down and slap her legs apart but they were slapping her on her arms, her body, her torso....

She was in the throes of labor, in a lot of pain, hadn't been given any morphine, and the midwives ... were verbally very abusive, they said ... how much she's going to tear, if they don't allow us to assess her....

Health care providers often violated patients' right to confidentiality, as

exemplified by this student's description of a bedside discussion:

They said words like her "CD4 count," "immuno suppressed" and ... so my clinical partner and I were just standing there.... By the way, this was without her consent, and the reason I think her employer [who was at the bedside] would have realized that it was HIV, was the way they expressed it.

Professional lapses described by students included disrespect toward patients, irregular procedures and treatments (e.g., inappropriate palpation of mother's womb prior to delivery, blood in the vacutainer), and inadequate information given to patients about their diagnosis, treatment, and procedures. One student described a physician's infringement of a patient's right to a dignified death:

When we came back into the wards we heard that [the patient] had passed away. And that was incredibly distressing, we felt so guilty that we had taken this man's last hours for a tutorial ... and we were just standing there while [the consultant was] giving us a tutorial on this man.... It was as if he wasn't there.

Using the survey responses, we classified students' opinions on the causes of abuses as health professional factors, health system factors, and patient factors. The main health professional factors cited by the 130 students who reported witnessing abuses were frustration of health workers (46; 35%), stressed and overworked medical staff (43; 33%), and "other" factors (46; 35%), which included disregard and disrespect for patients, ignorance of patients' rights, laziness, negligence, and inadequate supervision of staff. Principal health system factors were overburdened health care facilities (24; 18%) and understaffing (15; 12%). Uninformed or disempowered patients (11; 8%) and language barriers (9; 7%) were the patient factors cited most commonly.

Racial and ethnic discrimination was not a significant theme emerging from the 28 interviews, but there were examples given of African (6; 21%) and multiracial (3; 11%) patients who were vulnerable to abuse. Many interviewees (19; 68%) said that patients were more likely to be abused if they were teenagers or were not following procedures. These patients were deemed "troublemakers" by the midwives. One student offered the following description of the causes of abuse in an MOU:

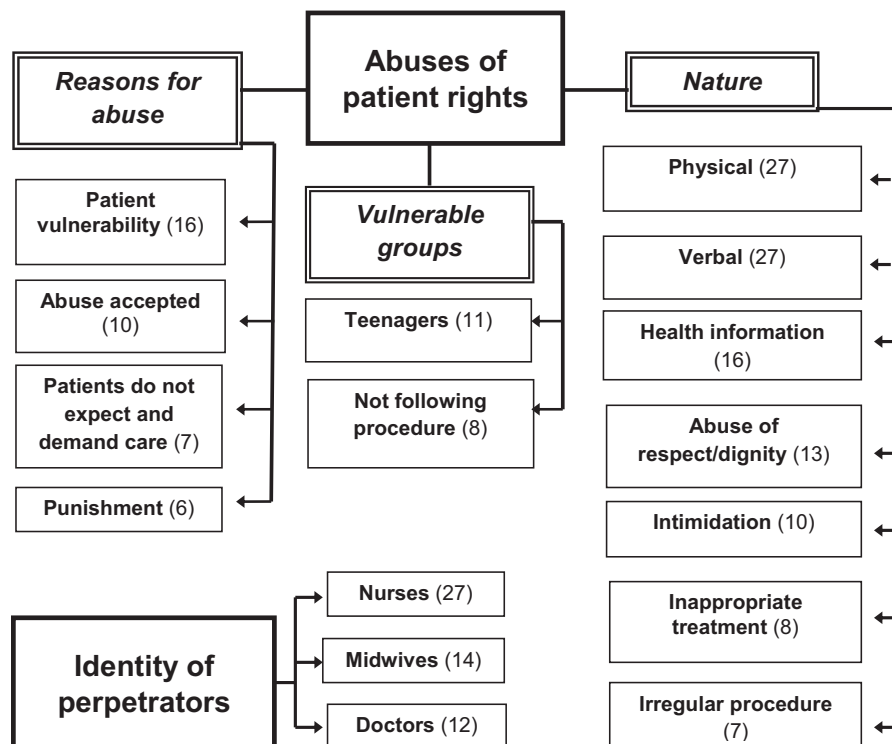


Figure 1 Abuses of patient rights described in interviews by 28 medical students of the University of Cape Town Faculty of Health Sciences, 2009. This figure illustrates two of the relevant themes that emerged from the interview data: abuses of patient rights and identity of perpetrators. Numbers in parentheses indicate the number of incidents reported and thus include multiple responses from individual students. The figure ranks the nature of the most-common abuses against patients, the groups of patients whom students considered to be most vulnerable to abuse, and students' perceptions of the reasons for abuse. Below, the identity of perpetrators is ranked according to the number of abuses of patients' rights witnessed by students.

Any woman was certainly vulnerable to being abused in the situation but I saw that the midwives reacted quite negatively towards teenagers who were giving birth ... anyone who wasn't going through labor in a way that they wanted them to ... anybody who was having trouble, or who had a low threshold for pain, or who cried, or screamed....

Identity of perpetrators

In the survey and interviews, students named nurses as the main perpetrators of abuse, followed by midwives and doctors (Figure 1). They felt that patients generally accepted abuse. One interview comment reflected a concept of cultural relativism with respect to abuse:

One of my classmates ... was telling me that she is very used to that [abuse] because in her culture that's commonplace. An elderly woman is free to be physically and verbally abusive ... but when a woman's in labor ... whether it's your culture or not, I just didn't feel it was the kind of behavior that's appropriate.

Student responses to abuses

Among the 130 students who indicated on the survey that they had witnessed abuses, 77 (59%) reported that they had not responded to the situation. One interviewed student's rationale for not responding was typical:

Students are prepared ... because of our knowledge in PHC and Patients' Rights Charter.... I know when a patient's right is being violated ... [but I am] unsure as to the route and method I would have to take to challenge any violation I may witness.... I feel cynical about health care institutions' response.

Of the 53 students who indicated on the survey that they had responded to the abuse in some way, 15 (28%) had intervened and attempted to remedy the situation. Twelve (23%) students had questioned the perpetrator, 11 (21%) had reported the abuse to medical teaching staff, and 11 (21%) had reported it to hospital staff. When interviewed, one student explained, "I expressed my disgust at their treatment of patients.... It

is my duty to defend the rights of patients." Another stated, "I asked the nurse to use local analgesia while suturing or get it and make it available for [the patient]." Students' primary reason for responding was to defend patients (23; 43%). Despite responding, some of these 53 students described feeling helpless (6; 11%), fearing reprisal (5; 9%), and fearing to challenge their seniors (4; 8%).

During the interviews, some students demonstrated a developing moral and ethical identity as health professionals by acknowledging their own feelings (Figure 2). Four of the 28 (14%) interviewees said that nothing could have prepared them to cope with what they had witnessed, and another 2 (7%) felt that they did not cope at all. Three (11%) students reported that they had laughed in reaction to what they and their peers had witnessed, and others laughed when reflecting on their experiences in their interviews. Others described feeling shocked (17; 61%), angry (14; 50%), and guilty (2; 7%).

However, as reported above, the majority of students who witnessed abuses of patients did not report incidents. Some (14/130; 11%) were cynical about whether reporting abuses would make any difference. One student explained in an interview:

We actually wrote down specific instances in the evaluation form. But no one ever got back to us, we don't know if anything was done about it. At one ... MOU, we actually wrote a letter to the sister [nurse] who was in charge.... We gave all the grievances that we had. And we named specific patients, sisters, everything and incidences ... but nothing was done.

Of the 77 students who did not respond to the abuses witnessed, 11 (14%) indicated that they did not respond because of a fear of reprisal. Common reasons for not responding were a lack of experience, being afraid to challenge their seniors, and fearing that antagonizing nurses and midwives would be detrimental to their academic progress. One interviewed student explained what had happened to a fellow student:

One of the students ... said something to the nurses and they completely shut her out of the ward almost. They wouldn't let her do anything and they refused to sign her logbook and one of the nurses even hit her....

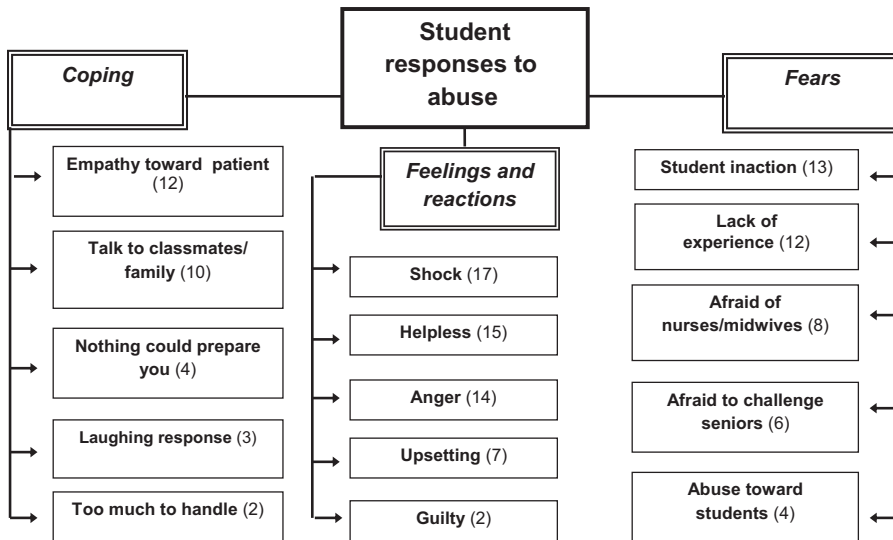


Figure 2 Student responses to abuse as described in interviews by 28 medical students of the University of Cape Town Faculty of Health Sciences, 2009. Numbers in parentheses indicate the number of incidents reported and thus include multiple responses from individual students. This figure shows the relationship between student inaction and fears relating to their lack of experience, lack of confidence to speak out, and fear of reprisal; ranks students' feelings and reactions, showing shock and helplessness to be the most common; and ranks students' strategies for coping with the patient rights abuses they witnessed.

Another student commented, "We know what to do, but doing it is difficult around senior staff when they violate these rights."

Both in their written comments on the survey and during the interviews, students explained that they addressed abuse by consoling patients and forewarning them of potentially abusive situations. In an interview, one student commented:

My intervention strategy was to actually talk to the patients and warn them. So the next teenager that came in[to the MOU], I got to her first and ... warned her, please do what they say, don't scream, I know it's going to be sore, I'll do my very best to get you your medication.

Only 62 (34%) of the 183 survey respondents felt prepared to challenge abuses in the future, whereas 39 (21%) felt unprepared and 78 (43%) were uncertain. Reasons cited by the 78 students for their uncertainty included not knowing how to report abuse (19; 24%), fear of challenging their seniors (13; 17%), and lacking clinical experience (14; 18%).

Discussion

In comparison with studies conducted in the United States,^{5,6,8} this study found a high prevalence of patient rights abuses witnessed by medical students of the

UCT Faculty of Health Sciences in South Africa. Students' responses indicated that they felt there was a general abuse of power by physicians, nurses, and midwives. Their interviews reflected that a lack of supervision contributed to controlling and abusive behavior by nurses and other health care workers. With respect to perpetrators, interviewees argued that nurses and doctors were poorly trained in professionalism, and they questioned whether abusive behavior has become institutionalized in South African hospitals.

Jewkes and colleagues¹⁴ have argued that the training of nurses in South Africa has long been linked to notions of "moral superiority," moral instruction, and rituals of subordination and that the lack of local accountability and inaction against abusers is to blame for their perpetual and commonplace violence toward patients. Nurses sometimes justify their abuse of patients by deeming them to be "inferior," "ignorant," or "bad patients."^{14,15} Our study found similar attitudes among nurses and midwives as well as evidence that these authors' analysis applies to doctors. Shortages of professional health workers, high workload, low staff morale, and long working hours were cited by nursing students in another study as significant stressors in South African health facilities.¹⁶

Our study confirms London and colleagues⁷ report that most health professional students in South Africa have little awareness of how human rights issues relate to clinical practice or of their obligation to protect and promote human rights. For instance, medical students in this study often cited ethical misdemeanors (e.g., lack of confidentiality) as patient rights abuses, which suggests that they failed to distinguish between professional lapses and abuses requiring disciplinary action. London and colleagues⁷ caution that if appropriate role models are absent during clinical training, students' earlier learning is undermined, and the students may think that advocating for patient rights is not their responsibility. This was illustrated in our study by a majority of students reporting that they had not responded to the abuses they witnessed; among the fears they described was that of challenging their seniors, which has been reported by other authors.^{5,17,18} Students' coping strategies demonstrated their attempts to juggle a developing sense of moral integrity with an emerging sense of professionalism, concern for patients, and fear of retribution.

A strength of our study is that it provides detailed accounts by senior medical students of abuses and professional lapses witnessed in a diversity of settings during their clinical training. Moreover, it seems that this study provided the first opportunity for these students to confide in and reflect on their experiences with a senior member of the medical teaching staff (L.V.). The good response of fourth- and fifth-year students to being interviewed may reflect a deep sense of dissonance between their ideals of health professional behavior and the actions of their clinical teachers; this suggests that they may be experiencing moral and ethical conflicts.^{19,20} Disturbingly, students may feel pressured to collude in unprofessional behavior, leading to further confusion and distress.²¹ This may be the reason why only one-third of students reported on the survey that they felt prepared to challenge abuses in the future. The limitations of our study are that it is a single-institution study and may not be generalizable to other countries either in a developed or developing world context. In addition, final (sixth)-year students were underrepresented in the survey sample,

and only one participated in the interviews.

Students' complaints that nothing was done in response to their reports of patient rights abuses and unprofessional behavior have been recognized by the faculty, as has their recommendation that protocols and procedures be put in place for reporting abuses while maintaining confidentiality. The study lent impetus to the establishment in November 2010 of a professional standards committee in the UCT Faculty of Health Sciences to promote awareness of professional standards among staff and students, to receive complaints about unprofessional behavior, and to support those who speak out. Despite the difficulties of speaking out, students will be encouraged to do so to improve the quality of patient care, to prevent the recurrence of abuse, and to strengthen ethical and accountable practice. Students also called for human rights education for patients and staff, as well as for disciplinary action to be taken against perpetrators of abuse. The latter has occurred against some offenders in the MOUs.

In conclusion, this study adds to the published evidence of patient rights abuses and professional lapses in health care settings around the world.^{5,6,8,17,22} It demonstrates that qualitative methods can be employed to evaluate medical education and to monitor ethical conduct in the academic clinical setting and that medical ethics and human rights should be aligned with and supported by medico-legal protocols in teaching and clinical practice.

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