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Commentary

It's Time to Act More Rigorously: Zero-Tolerance Policies in Medical Education

Mir Hossein Ahmadi[1] and Reza Abdoolahi[2]*

1. Khalkhal School of Medical Sciences, Khalkhal, Iran
2. Faculty of Nursing and Midwifery, Urmia University of Medical Sciences, Urmia, Iran

Zero-tolerance policies are increasingly implemented in medical education to address student mistreatment and uphold professional standards. These policies aim to foster a positive, equitable learning environment free from discrimination, harassment, and abuse. However, their application, particularly in complex settings like emergency departments, raises challenges regarding patient access, behavioral nuances, and equitable enforcement. This article explores the scope, implementation, challenges, and reporting mechanisms of zero-tolerance policies, with a focus on medical education and their broader implications (1).

Many medical institutions, such as the University of Oklahoma College of Medicine, Harvard Medical School, and the University of Miami Miller School of Medicine, have adopted explicit zero-tolerance policies against medical student mistreatment. These policies condemn behaviors that disrespect the dignity of others or disrupt the learning process, whether intentional or unintentional. The Association of American Medical Colleges (AAMC) defines mistreatment as actions such as public humiliation, discrimination based on gender, race, ethnicity, or sexual orientation, physical harm, or unwanted sexual advances (2).

To be effective, zero-tolerance policies require consistent reinforcement, especially during critical transition periods like clerkships or residency onboarding. The Association of Schools and Programs of Public Health (ASPPH) issued a 2019 statement advocating for zero tolerance of harassment and discrimination in academic public health institutions, emphasizing institutional leaders' responsibility to foster safe environments. These policies are often supported by clear reporting mechanisms, such as anonymous hotlines or direct communication with faculty, to encourage accountability (3).

While zero-tolerance policies aim to ensure equitable learning environments, their implementation faces significant challenges. Critics argue that these policies often apply predetermined consequences without considering situational context, leading to potential inequities. For example, studies have highlighted that students with emotional or learning disabilities, or those from racially diverse backgrounds, may face disproportionate punishment due to behaviors beyond their control or biased enforcement. These disparities can lead to

*** Corresponding author**
Reza Abdollahi, PhD Student in Nursing
Faculty of Nursing and Midwifery, Urmia University of Medical Sciences, Urmia, Iran
Tel: +98 9019753320
Email: rezaabdollahi97@yahoo.com

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long-term consequences, including reduced academic performance, mental health challenges, and lower retention rates among marginalized groups (4).

Moreover, the rigid application of zero-tolerance policies can create a chilling effect, discouraging nuanced discussions about behavior or intent. For instance, a faculty member's unintentional microaggression might be penalized as severely as overt harassment, potentially stifling open dialogue about cultural competence.

Addressing these criticisms requires policies that balance accountability with context, incorporating training on implicit bias and restorative justice approaches to mitigate harm without disproportionate punishment (5).

The application of zero-tolerance policies extends beyond medical education to clinical settings like Emergency Departments (EDs), where their implementation is particularly complex. Hospitals have a legal and ethical obligation to ensure a safe workplace for staff, but strict zero-tolerance policies, such as banning disruptive patients, can conflict with patient care duties. Patients with conditions like intoxication, dementia, or psychosis may exhibit disruptive behavior due to their medical state, complicating enforcement. Rather than a blanket zero-tolerance approach, some EDs adopt a "100 percent response policy," which commits to investigating and mitigating every incident while prioritizing safety and care, particularly for marginalized populations with complex needs. For example, at Regions Hospital, behavioral agreements outline specific prohibited behaviors and consequences to manage disruptive patients. This policy functions through initial discussions with the patient, sharing the facility's policy on disruptive behavior, and implementing the agreement with clear steps for reporting violations, review by a multidisciplinary team, and follow-up actions such as warnings or restricted access. Alternative strategies include de-escalation training for staff, behavioral contracts for patients, and multidisciplinary teams to address underlying medical or social factors driving disruptive behavior. These approaches balance the need for a safe workplace with equitable patient access, acknowledging the nuances of medical conditions (6).

Effective zero-tolerance policies rely on robust reporting mechanisms. Harvard Medical School offers an anonymous ALERT Reporting Hotline and encourages reporting through course evaluations or direct communication with the Dean for Students. The University of Oklahoma College of Medicine provides multiple channels, including course directors, associate deans, or a student ombudsperson. These reports must be handled fairly and expeditiously to maintain trust (1). Despite these mechanisms, some studies indicate that reporting rates remain low due to barriers such as a "culture of silence," fear of retribution, and skepticism about institutional follow-through. The effectiveness of these mechanisms can be evaluated through indicators such as reporting rates, resolution timelines, satisfaction feedback from reporters, and periodic surveys on the learning environment. To address this, some institutions have implemented successful reforms. Regular assessments of inclusivity perceptions among learners and faculty can further support a culture of accountability and trust (6).

Table 1. Zero-tolerance policies in medical education

Recommendation	Description
Clear definitions	Develop and disseminate precise definitions of mistreatment, aligned with AAMC guidelines, to ensure all stakeholders understand prohibited behaviors
Reporting and investigation procedures	Establish multiple anonymous reporting channels and standardized investigation processes with defined timelines (*e.g.*, initial review within 48 hours, resolution within 30 days)
Protection for reporters	Implement anti-retaliation policies and provide support services for those who report mistreatment
Necessary training	Mandate regular training on de-escalation, implicit bias, and restorative justice for faculty, staff, and students
Ongoing evaluation	Conduct annual surveys and audits to assess policy effectiveness, reporting rates, and inclusivity perceptions, adjusting policies based on findings

Conclusion

Zero-tolerance policies in medical education are critical for fostering safe, equitable learning environments but face challenges in implementation and broader application. In medical schools, these policies must address disparities in enforcement and incorporate context to avoid harming marginalized students. In emergency departments, balancing staff safety with patient care requires flexible strategies like de-escalation and trauma-informed care. Robust reporting mechanisms, coupled with reforms like bystander training, can improve outcomes and combat the culture of silence. By addressing these complexities, medical institutions can uphold professional standards while promoting inclusivity and fairness.

biyad edameye jomleh bala the practical application of these policies, table 1 shows actionable recommendations for institutions.

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Conflict of Interest

There was no conflict of interest in this manuscript.

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