

Patient Harassment of Medical Trainees

Reflections for a More Inclusive Future

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Introduction

In the era of the #MeToo and Black Lives Matter movements, there is considerable attention paid to and literature chronicling harassment and abuse of medical trainees by their faculty, supervisors, and fellow health care workers. However, a relatively neglected aspect of trainee mistreatment is the harassment and bias trainees endure from patients and their families. Such situations carry unique stressors for trainees. In this article, 2 female hematology and medical oncology fellows (with one being Black and the other White) discuss examples and propose responses to this important failure of the physician training environment.

Example 1

An older man presented to the oncology clinic with a new diagnosis of metastatic colon cancer. After his vital signs were taken, a female physician trainee called him from the waiting room, introducing herself as "Dr X". As they walked toward the examination room, the patient commented on how others will be jealous that he has a pretty girl as his doctor. Ignoring the comment, the trainee seated the patient and accessed his electronic record. As she began the consultation, the patient grabbed her hand and asked if she was married or had a boyfriend. The trainee attempted to redirect the visit and addressed the patient with the honorific "Mr" and his last name and explained "We are here to talk about you, not me. Tell me what you understand about your cancer diagnosis."

Example 2

A White adult man with a recent diagnosis of advanced cancer presented to the oncology clinic to discuss adjuvant therapy options. A physician trainee, who is a Black woman, called him from the waiting room. Seeing her, the patient's previously casual demeanor appeared hostile, as he scowled and furrowed his brow. The trainee explained that she would be his primary oncologist with supervision by an attending physician. She then discussed the pathology of his cancer diagnosis and disease state and recommended adjuvant therapy. She explained the risks and benefits of treatment, providing him with printed literature on the recommended therapy. The patient explained that he needed more time to think about his options. When the attending physician, a White man, entered the room, the patient assumed a noticeably more pleasant affect and agreed to return in a few weeks.

A few weeks later, the patient frowned as the trainee escorted him to the examination room. When asked about his treatment decision, he complained that the literature he was given was not useful and he was unsatisfied with his own internet research. He demanded to

know his exact odds of experiencing each of the listed adverse effects of the recommended treatment. When the trainee offered to look up and share the clinical trial data so that they could review it together, the patient responded that this showed that the trainee did not know what she was doing. The trainee responded that she would get the attending oncologist, to which the patient criticized the trainee for walking out on him. When the White male attending physician entered the room with the trainee, the patient was immediately calm and pleasant. The attending physician reiterated that it was impossible to know the exact risk for every potential adverse effect for an individual patient, but that educated estimates based on data from clinical trials and the patient's specific comorbidities could be provided. The patient told the physicians that he did not want the trainee involved in his care. The visit concluded, and the patient was reassigned to an oncology team with no Black members.

Discussion

Many supervising physicians may be surprised to learn of how often women trainees encounter sexual harassment and sexism during patient encounters. Studies suggest that 53% to 65% of all women physicians in the US have experienced some form of sexual harassment from patients and/or their families, as demonstrated in Example 1.^{1,2} The Accreditation Council for Graduate Medical Education's Milestones for Clinical Competency places appropriate value on the patient-physician relationship and some training programs use direct and confidential "patient feedback" questionnaires in considering a trainee's evaluation and promotion. This contributes to a culture in which trainees are overly tolerant and hesitant to report patient misbehavior. This, in combination with a sense that their faculty or institutions will be unsupportive or unresponsive, contributes to underreporting of sexual harassment and other macroaggressions and microaggressions.

Supervising physicians can address patient sexism in many ways. Proactively, they should refer to trainees appropriately with "Dr" and their last name any time they are in front of patients. Any witnessed accounts of sexism should be strongly and directly addressed rather than ignored. Even seemingly mild comments about a trainee's physical appearance can be quickly ameliorated by a senior team member: "Dr X is an intelligent physician, and that is what matters when she is taking care of you." When witnessed or reported, questions about a trainee's personal life or invitations should be explained to the patient as inappropriate and unacceptable in the interest of both the patient and the trainee. More egregious situations, including inappropriate physical touch or

groping, should be handled directly, with a priority placed on the trainee's physical safety. Systems-based approaches should also be considered. Chaperones can be made available for patient encounters, and examination rooms can be arranged such that the clinician sits closest to the clinic room door to limit a patient's ability to bar the exit should a clinician need to make a quick exit for safety. Explicit policies regarding patient conduct should be in place, and training programs should be quick to remove disruptive or aggressive patients from the care of trainees.

Dealing with a patient's racial animus can be significantly distressing for the physician involved. As we saw in Example 2, the Black female trainee of color is often in triple jeopardy, left to wonder toward which of her identities—trainee, female, or Black individual—this hostility is directed. When it is perceived as racial hostility, the trainee's report may be dismissed as hypersensitivity and downplayed by faculty. Such minimizing ignores the effect on the trainee, further exacerbating feelings of shame, embarrassment, pain, anger, stress, and burnout.³

Patients have a right to refuse care, but degrading or belittling a trainee because of their identity should not be condoned in the practice of medicine. Most often, trainees subjected to this type of behavior by patients are unable to truly speak up owing to the power

dynamic and fear of retribution.⁴ Their situation is similar to that of the trainee experiencing sexual harassment, but at most training institutions, trainees who identify as members of racial and ethnic minority groups that are underrepresented in medicine have significantly fewer colleagues to whom they can turn for support. Thus, the role of the faculty and institution is amplified. Are inclusion and respect simply trendy or are they intentional and integral to the culture of the institution? Are faculty offered training in unconscious bias and other relevant diversity and inclusion topics, or do they simply "play it by ear" based on their own privileged life experiences with little empathy for the experiences of their racial and ethnic minority trainees? In the example presented, not only was the patient reassigned with the consent of the trainee, but the trainee was able to debrief with her attending and peers.

Many medical institutions do not have policies addressing discrimination against their employees who identify as racial, ethnic, and gender minority individuals, except as required by federal laws; policies specific to harassment and discrimination from patients toward trainees are even more rare.⁵ These 2 examples offer illustrations of the need to consider the experiences of trainees as medical centers develop meaningful policies that address bias toward all health care workers.

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