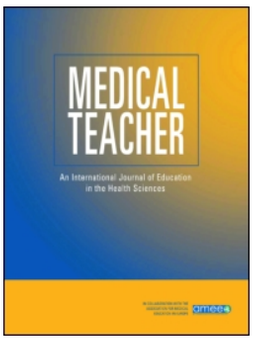

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PERSONAL VIEW

When patients hurt us

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ABSTRACT

In this thoughtful article, medical educators in various stages of their careers (resident, mid-career clinician-educators, medical school deans) reflect upon increasing reports of harassment and mistreatment of trainees by patients. In addition to providing a general overview of the limited literature on this topic, the authors describe their own experience collecting information on trainee mistreatment by patients at their institution. They explore the universal difficulty that educators face regarding how to best address this mistreatment and support both faculty and trainees. Given the current sociopolitical climate, there has never been a more urgent need to critically examine this issue. The authors call on the greater medical education community to join them in these important conversations.

Many of us have a memorable "patient story" – the time we delivered reassuring news to a grateful family, when we comforted a devastated family, when we helped save a patient, or the time we lost someone. Many of us also have *those* patient stories – the kind that evokes not bittersweet memories, but a dull ache in the pit of our stomachs. We share these stories in hushed tones in the company of peers, and sometimes we do not share them at all, struggling in silence. Last week over coffee, our colleague described how an elderly male patient let his hand inappropriately linger on her body after an impromptu hug, stating, "Gosh, you are too beautiful to be a doctor." This morning, while supervising a medical student wearing a hijab, an Iraqi war veteran expressed disdain after realizing she was part of his treatment team. These examples of mistreatment by patients are not anachronistic anecdotes: our predecessors remember these stories; we remember these stories; students and residents are still living these stories. As medical educators, have we been silent too long?

The Association of American Medical Colleges Graduation Questionnaire, the "GQ," given annually to all graduating medical students, defines mistreatment as any behavior, intentional or unintentional, that shows disrespect for the dignity of others and unreasonably interferes with the learning process (AAMC 2017)." Examples include sexual harassment; discrimination based on race, religion, ethnicity, gender, or sexual orientation; humiliation; psychological or physical punishment; and the use of grading and other forms of assessment in a punitive manner. The GQ asks students about their experiences of mistreatment by faculty, nurses, residents/interns, other staff, and fellow students, but they are specifically asked to exclude mistreatment by patients. Have we, as medical educators, implicitly accepted that mistreatment by patients is normative and therefore not worth measuring or requiring a response? If so, we have work to do.

Like most medical schools, our institution routinely surveys trainees regarding their experiences with harassment and mistreatment. Historically, these reports were monitored most closely for mistreatment by supervisors, not patients, and rarely was action taken if the harassment stemmed from the patient. In fact, students were encouraged to see harassment by patients in the context of their illness as a way of understanding, which leads to excusing that behavior. Hoping to learn more about the prevalence of mistreatment of students by patients at our institution, we informally reviewed five years of medical students' narrative reports of mistreatment by patients. The reports revealed themes of sexual harassment, inappropriate physical contact, ethnic stereotyping, and verbal abuse, among others. One student reported having their "crotch grabbed" when performing a physical exam, while another endured not only disrespectful references to race or gender, but also that "preceptors perpetuated these casual remarks at times."

While academic leaders are rightfully focused on identifying and eliminating trainee harassment by supervisors, we would be remiss in neglecting to address the same behavior by patients. What is disheartening in our review is that we frequently fail to intervene, and frequently fail to consider the cumulative effect of these unacknowledged exposures on trainees. Dvir et al. (2012) reported residual effects among trainees mistreated by patients including increased vigilance, avoidance of certain patient types, increased anxiety, and a change in career interest.

When faced with mistreatment by patients and families, trainees may struggle with when and how best to respond. Understandably, supervisors may also struggle with how best to support trainees. Our limited internal review indicates that in only four of 24 mistreatment reports did students indicate receipt of support or acknowledgement of the event from team members afterward. Moreover, acknowledgement by the team of mistreatment, when it

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takes place, is not always supportive as students are sometimes advised to "deal with it." It is clear that faculty and trainees alike need training in when and how to address such mistreatment, how to support trainees and peers who have experienced mistreatment, and how to institutionally promote a culture of respect and inclusivity in the clinical setting. Accomplishing these goals is a complex task, but we can start by recognizing and addressing mistreatment when it occurs in our presence. Through leading by example, and learning from mistakes along the way, we will equip trainees with strategies to use in these situations, both in the present and future as team leaders themselves.

Looking to the literature for ways to move forward, a study by Whitgob et al. (2016) provides a thoughtful, multipronged approach to addressing discrimination toward trainees. The authors share practical strategies for faculty and trainee development, including early orientation and awareness about mistreatment and avenues to seek help; cultural competency and implicit bias training; and simulated patient encounters to generate discussion and consider potential responses. For frontline faculty, the authors suggest frequent team debriefing and personal reflection after such events. They ask institutions to consider a multidisciplinary task force to spearhead policy, educational efforts, and the utilization of trainee mistreatment surveys with protocols in place to address events as they occur. At our institution, we have begun examining reports of trainee mistreatment by patients and have implemented case-based training for faculty members and trainees to explore approaches of dealing with a variety of patient mistreatment scenarios. We acknowledge the complexity of handling these experiences, given the variation in setting of care and acuity of patient illness, as well as the emotional responses and personality styles of parties involved. We recognize that in the throes of illness, our patients who hurt can also hurt us. Although there is no one "right way" to intervene, raising awareness and opening the door for conversation among peers and supervisors can be incredibly powerful.

We continue to explore the different forms of mistreatment that our trainees experience and study the different forms of "support" that can be offered. We invite other institutions and the Medical Education community to join us in critically examining this underreported phenomenon for the purpose of protecting our trainees from harm, equipping our community with more effective methods to address and respond to mistreatment by patients.

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