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"I don't want someone like you taking care of my child." **Strategies to address discrimination towards physicians by patients and families**

Association of Pediatric Program Directors

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Disclosures

The authors have no financial relationships to disclose or conflicts of interest to resolve.

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Welcome and Introductions

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Objectives

- Describe potential forms of discrimination by patients and families
- Develop approaches for responding when these situations occur
- List 3-5 strategies for educating faculty and trainees

Activity 1. Think-Pair-Share

- How familiar or frequent is mistreatment towards providers by patients and families?
- Have you observed patient or family discrimination against a trainee, colleague, nurse, or other member of the health care team?
- Have you experienced it yourself?
- How did the target of discrimination respond?
- What worked, what didn't? Why or why not?

Background

- Mistreatment of medical trainees is pervasive[1,2]
- Between 17 and 95% of trainees report some type of mistreatment [3,4,5]
- Only one study examined mistreatment by patients [6]
  - Patients accounted for nearly 40% of discriminatory behavior
- No recommendations for how to effectively respond to this discrimination

1. Brooks, 2015.
2. Reynolds et al, 2015.
3. Mavis et al, 2014.
4. Baldwin et al, 1997.
5. Fnais et al, 2014.
6. Crutcher et al, 2011.

Activity 2. Small Group Break-Out

- In groups of 3-4, read your case scenario
- Reflect on the scenario and outline an effective response from:
  - The trainee
  - The attending
- Select one group member to be the spokesperson to share your scenario and responses with the large group

Activity 2. (cont'd)
Large Group Share & Discussion

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- Questions for the small group:
  - What responses did your group come up with? Why?
- Questions for large group:
  - How would you respond as the trainee? Why?
  - How would you respond as the attending? Why?
- What came up for you/your group during this experience?
  - Areas of disagreement, confusion, agreement
  - How did you make final decisions about how to respond?

Case 1: Race

When an African American junior resident walked into a newly admitted Caucasian infant's hospital room the child's mother, also Caucasian, stood and blocked the resident's path to the child. The mother did not move and told the resident, "I want someone else to examine my child; I do not want your kind to touch her." The mother went on to say that she did not want a "diversity quota doctor" to take care of the child but someone who was "actually smart" and could treat her daughter's illness.[8]

8. McDade, 2001.

Case 2: Gender

A male medical student walks into an OB/GYN clinic room and introduces himself to an adolescent patient and her mother. The mother asks if she can step outside with him. Once they are in the hallway the mother tells the student that she does not want a male practitioner examining her young daughter. “She’s never had a pelvic exam before. I’m worried the experience will be worse for her with a man involved.”

Case 3: Religion

An intern working in the Emergency Department returned to a toddler's exam room after presenting the child's case to her attending. She explained to the parents that she was calling a consultant for a surgical evaluation. The patient's father pointed to the intern's badge and asked if her last name was Jewish. She replied, "No," and the father then asked if the surgeon was Jewish. "I don't want a Jewish doctor," the father said, "I'm from Palestine."

The Discriminatory Patient and Family: Strategies to Address Discrimination Towards Trainees

Emily E. Whitgob, MD, MEd, Rebecca L. Blankenburg, MD, MPH, and Alyssa L. Bogetz, MSW

Abstract

Purpose
Trainee mistreatment remains an important and serious medical education issue. Mistreatment toward trainees by the medical team has been described; mistreatment by patients and families has not. Motivated by discrimination towards a resident by a family in their emergency department, the authors sought to identify strategies for trainees and physicians to respond effectively to mistreatment by patients and families.

approach, semistructured one-on-one interviews were conducted. Participants were asked to describe how they would respond to clinical scenarios of families discriminating against trainees (involving race, gender, and religion). Interviews were audio-recorded, transcribed, and anonymized. The authors analyzed interview transcripts using constant comparative analysis and performed post hoc member checking. This project was IRB approved.

wanted trainees to feel empowered to remove themselves from care when necessary but acknowledged that removal was not always possible or easy. Nearly all participants agreed that trainee and faculty development was needed. Suggested educational strategies included team debriefing and critical reflection.

Conclusions
Discrimination towards trainees by patients and families is an important

Practical Strategies from the Stanford Study

as they progressed through their training.

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physicians, peers, and members of the medical staff. In 2013, the Accreditation Council for Graduate Medical Education was also charged to address this problem in residencies.[4-6]

Numerous studies published in the last five years have found that trainee mistreatment and discrimination is a widespread phenomenon with between 17% and 95% of trainees reporting its occurrence.[5,7,8] Variable forms of abuse have been reported. One meta-analysis found that verbal harassment was the most common form, with discrimination based on gender and race most prevalent, ranging from 4% to 19%, respectively.[8] Although definitions of mistreatment vary, we use the definition offered by

medical education, and even less is known about the nature of mistreatment from patients and their families. One study of first-year residents found that of nearly 400 respondents, 93% had experienced "disruptive behavior" including abusive language, gender and racial bias, berating, and exclusion from decision making.[9] To our knowledge, only one study has examined the prevalence of discrimination and other forms of mistreatment towards trainees by patients. This study found that patients accounted for nearly 40% of this behavior.[10] In 2015, we conducted a survey of all pediatric residents at our institution and found a disproportionately high rate of patient and family mistreatment towards

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Method
Design, Sample, Data Collection

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- Members from Pediatric Faculty Program Evaluation Committee
  - Clinical and teaching responsibilities
  - Leadership positions
  - Emailed individual invitations to participate from April-June 2014
- Data Collection
  - Individual interviews using semi-structured guide; trained interviewer
  - 3 case scenarios of trainee discrimination (race, gender, religion)
  - Questions to probe reflection and responses
  - Interview guide pilot-tested prior to use
  - Continued until saturation of themes was reached[7]
- Qualitative, exploratory study. Stanford IRB approved

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7. Charmaz, 2014.

Results – Four Approaches

- Assess illness acuity
- Cultivate a therapeutic alliance
- Depersonalize the event
- Ensure a safe learning environment

Approach 1: Assess Illness Acuity

- How sick is the patient? Is there time to safely transfer care?
- Is finding another provider at your institution an option?
- Do you need to consider court order or Child Protective Services involvement?

Approach 1: Assess Illness Acuity

"It's an urgent versus routine thing. If we're just doing a routine checkup, it's one thing. If you're here to deliver a baby or the baby urgently needs attention and I'm the only person to provide the care, then there's not a lot of choice in the matter."

Approach 2: Cultivate a Therapeutic Alliance

- Build rapport
- Ask, “Why? What concerns you?”
- Explore biases without the intention of changing the family’s mind
- Redirect the conversation to focus on the child’s medical care: “I’m very worried about your child. Let’s focus on how we can help him/her.
- Educate the family on the team structure: “If you’re here in the teaching facility, everybody participates and that’s part of the bargain of having access to the expertise and participation of multiple people.”

Approach 2: Cultivate a Therapeutic Alliance

"Trying to get at what the real fears are can be helpful in building a trusting relationship. If you're willing to listen to them, explore 'What are the things that you're really concerned about? Tell me what you're afraid of. Tell me what your desires are….' It begins to build a trusting relationship, which is really critical."

Approach 2: Cultivate a Therapeutic Alliance

"If I think there's some mistaken thought that is contributing to this prejudice or to not wanting this provider to take care of the child, then I'm willing to go there. But if it seems to be a situation of just prejudice then I'm not going to get into that conversation. We're just going to focus on 'These are our providers. This is what we do. Let's focus on getting what you came here for.'"

Approach 3: Depersonalize the Event

- Remember discrimination is often motivated by patients' fears and anxiety about the unknown
- Acknowledge that discriminatory comments may be coming from family's lack of control
- Name the behavior to bring awareness: "Are you discriminating against this physician because of his name/skin color/gender/religion?"

Approach 3: Depersonalize the Event

"There's always a question of how much do you want to take on in a professional setting when you're trying to be professional but someone is challenging your beliefs or your feeling of what is right and wrong.... The emotional heaviness of this can be alleviated if you rest on your professional values.... I'm here to provide medical care for the child. The child is my patient, not the parent. Do no harm."

Approach 4: Ensure a Safe Learning Environment

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- Provide support and assurance of trainee competence
  - "I would trust this physician to take care of my own children."
  - "I agree with this physician. What other questions may I answer?"
- Speak to Risk Management
- Escalate to hospital administration and/or training director
- Empower the trainee to come up with next steps

Approach 4: Ensure a Safe Learning Environment

"There's need for follow-up when anything in the room comes up that was unexpected, let alone something so personal as this could be. Sitting down and having a one-on-one or even having the whole team discuss it is important because I think all residents will be discriminated against no matter what at some point in their career and need to learn skills to handle that … at hospitals these days a very big concern is patient satisfaction … that's of high importance to me as well. But I also think as educators, it's our responsibility to be protective of our learners and create as optimal an environment as we can, knowing they are going to have to deal with these things long-term."

Approach 4: Ensure a Safe Learning Environment

"I certainly would respect [the trainee] saying, 'Maybe this isn't something that I should be put through, and I don't want to have to deal with this family' or 'I know I can't give this patient the care he or she deserves now.' I would respect that if that was the choice they made. Or, if they felt like they wanted to continue to provide care, I would absolutely support them and be there to back them up … it can be hard for trainees to make these decisions though."

Results – Strategies for Education

- Trainee and Faculty Development
- Frontline Faculty
- Institution

Practical Strategies for Responding to Discrimination by Patients or Families – Penn State Health's Road to Change

- **PATIENT RESPONSIBILITIES**

The following patient responsibilities are presented to the patient and family in the spirit of mutual trust and respect.

- **Demonstrate Respect and Consideration**

  Patients, as well as their family members, representatives and visitors, are expected to recognize and respect the rights of our other patients, visitors, and staff. Threats, violence, disrespectful communication or harassment of other patients or of any medical center staff member, for any reason, including because of an individual's age, ancestry, color, culture, disability (physical or intellectual), ethnicity, gender, gender identity or expression, genetic information, language, military/veteran status, national origin, race, religion, sexual orientation, or other aspect of difference will not be tolerated.

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In addition, requests for changes of provider or other medical staff based on the provider's race, ethnicity, religion, sexual orientation or gender identity will not be honored. Requests for provider or medical staff changes based on gender will be considered on a case by case basis and only based on extenuating circumstances.

Penn State Health – How Did We Get Here?

- Physician interaction / Request by family member to replace primary hospitalist due to skin color
  - Chief Medical Officer / Associate Chief Medical Officer / Chief Nursing Officer immediately involved
  - Hospital Medicine group policy on transferring care between providers established
- Faculty experiences survey

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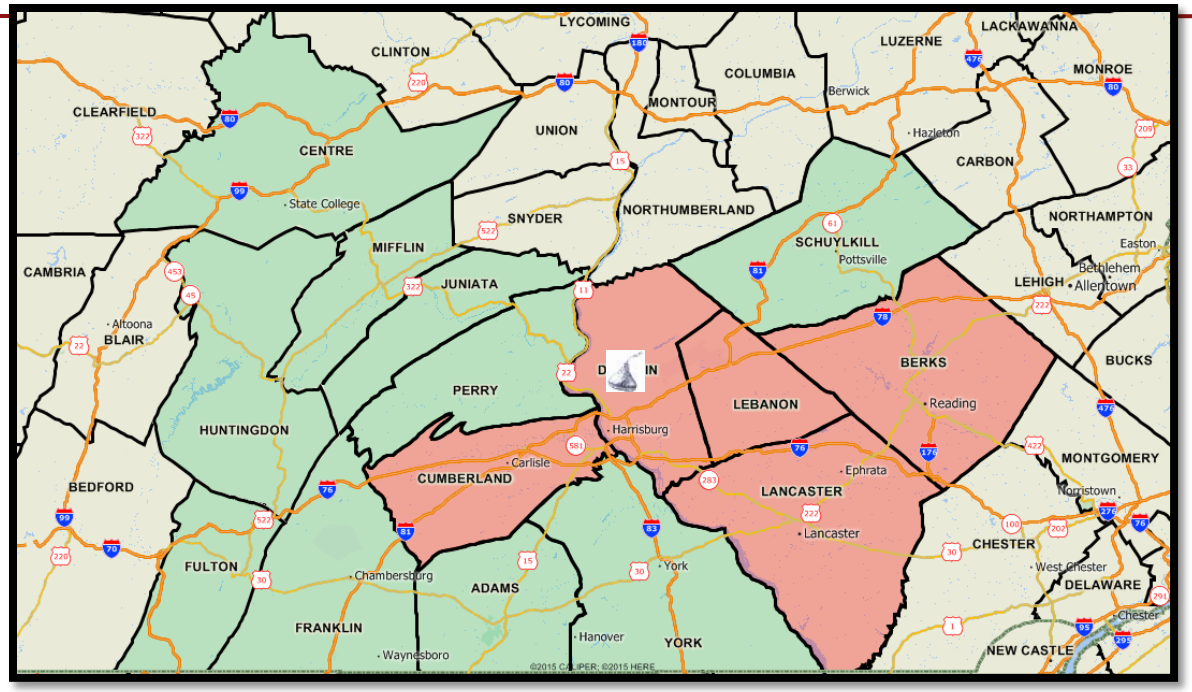
  - Southern Poverty Law Center data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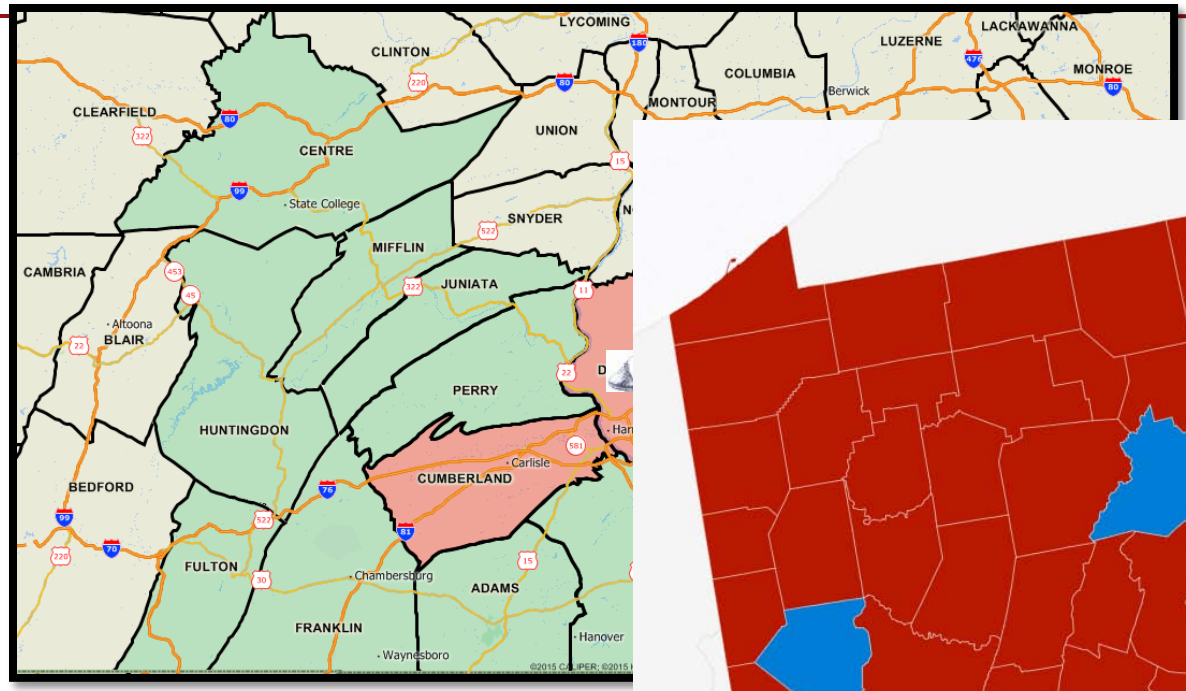
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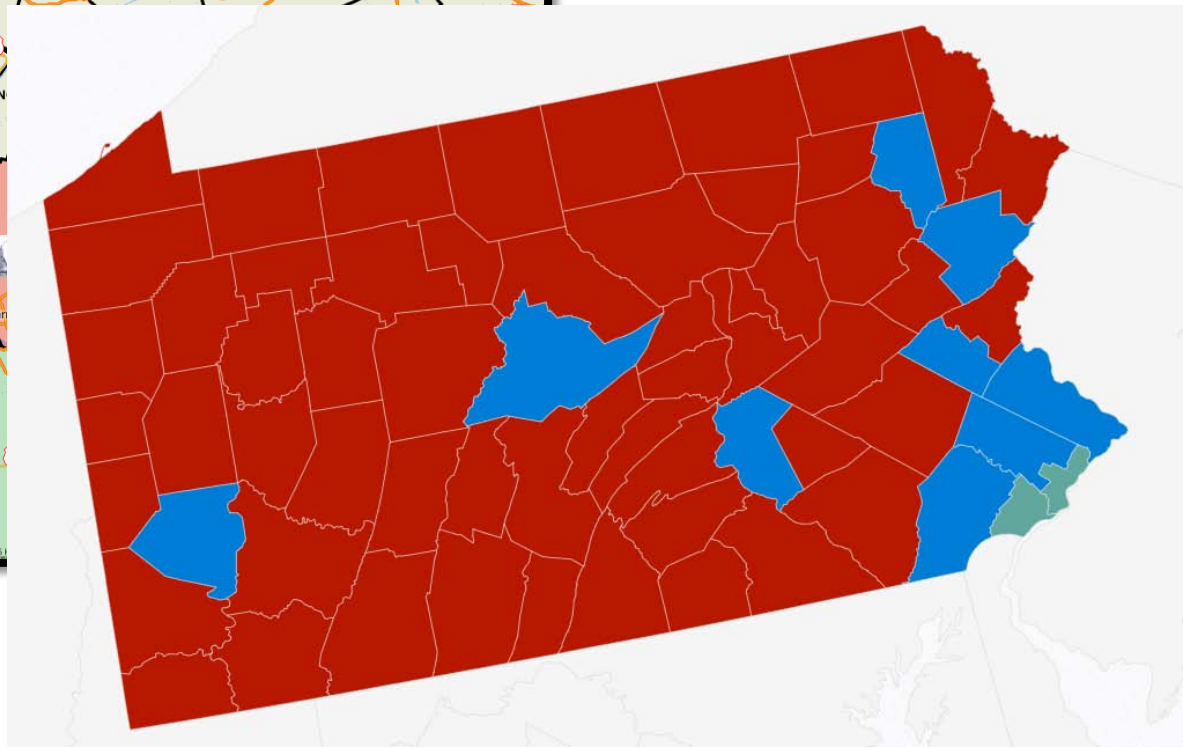

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  - Southern Poverty Law Center data
- Joint presentation to Penn State Health Executive Council (Dean/CEO, COO, Head of Penn State Medical Group, Clinical Chairs, etc.) → Senior Leadership Retreat

Next Steps…

- Faculty / Resident / Student Simulation Training
  - Standardized patients, Case-based scenarios
- Liaison with Patient Relations
  - Have moved their function from purely patient-centric to also allow for physicians to contact and involve them in cases as facilitators of communication
- Increase Real-Time Debrief via Penn State PAWS program
  - Leverages existing resources established for staff response to Rapid Response / Code Blue events
- Security Staff Training

Study Implications

- We must prepare trainees to address discriminatory patient encounters because prevention is impossible.[10]
- Case-based discussions unanimously recommended
  - Reflection on personal identity, beliefs, and attitudes
  - Reflection on personal boundaries and triggers
- Autonomy vs. protection
  - Give permission to step away

10. Irby, 1994.

Study Conclusions

- While physicians may vary in the degree to which they accommodate discriminatory preferences, their dedication to the care of their patients and to the protection of their trainees is constant
- Advance preparation through the strategies described can equip trainees and faculty to respond constructively in ways that ensure the safety and well-being of patients and trainees

Study Conclusions

- Our political and social climate is such that discrimination is at the forefront of many human interactions
- Our duty as medical professionals is to prepare our trainees, faculty, staff and administration to navigate these situations to the best of their abilities
- Explicit discussion about discrimination and its effects must be ongoing
- Trainee and faculty development must be championed

Closing

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Questions?

Thank you for being here!

Please complete the brief evaluation at your table.

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