Approaches for Residents to Address Problematic Patient Behavior: Before, During, and After the Clinical Encounter

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A resident discusses dialysis with her elderly patient, who later says, "You look too young and pretty to be a doctor!"

Microaggressions are "subtle, stunning, often automatic, and non-verbal exchanges which are 'put-downs.'"[1(p272)] Commonplace in medicine, these interactions can degrade one's health over time. Because of their subtle nature, they can be difficult to classify.[1] Discrimination in medicine is multidirectional, and all perspectives are a crucial part of the conversation. Here, we focus on microaggressions that occur from patient to medical trainee to provide targeted teaching tools to mitigate the impact of microaggressions.

Historically, medical training has promoted a culture of silence and submission—suggesting that, somehow, experiencing inappropriate behavior is a rite of passage.[2] Problematic patient behavior contributes to physician burnout, poor work performance, and avoidance of specific patients.[3,4] Medical education in the United States has not adequately addressed this problem. While many residents experience inappropriate behavior from patients, they lack specific strategies to respond.[5] The hidden curriculum in medicine around problematic patient behavior should become explicit to build trainee resilience. Studies from other health disciplines suggest that training on how to respond to inappropriate patient behavior reduces its negative impact.[6] Protecting our residents from the harm caused by inappropriate behavior is vital to ensuring the health of the workforce and, ultimately, our patients.

Embedded in the patient-physician relationship is a complex power dynamic. We must acknowledge the privilege of the physician in understanding patients' biopsychosocial contexts to reflect on difficult encounters and improve clinical care. Psychiatrist James Groves elucidated the importance of this:

> Negative feelings about . . . patients constitute important clinical data about the patient's psychology. When the patient creates in the doctor feelings that are disowned or denied, errors in diagnosis and treatment are more likely to occur. Disavowal of hateful feelings requires less effort than bearing them. But such disavowal wastes clinical data that may be helpful in treating the "hateful patient."[7(p887)]

The physician aims to get to know the patient better, forming a relationship built on mutual respect. The following tools may allow for reflection in order to build patient rapport, promote patient-centered care, and attend to resident well-being. While there is no one-size-fits-all approach to microaggressions, we offer an approach to the complex nuances of experiencing a microaggression that integrates a 3-pronged approach to address transgressions before, during, and after the clinical encounter.

Step 1: Before the Encounter

An Asian American resident anticipates his next patient interview at the VA, wondering what comment he will receive this time. In his previous interview, his patient asked, "Are you planning on returning to China after your training?"

It is crucial to prepare faculty and residents for discriminatory events before they happen. Setting expectations provides residents and supervisors with appropriate in-the-moment responses and prepares them for meaningful reflection and debriefing. It is the attending physician's role and responsibility to create a positive learning climate.

During orientation to clinical rotations, we learn about the values of team members, discuss how the team would prefer to address inappropriate patient behaviors, and prime residents with the skills to respond. Attending physicians make an explicit pledge to protect their learners as much as possible

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TABLE 1
Before the Encounter: Reflecting for Action

Principle	Suggested Language
1. Set the stage	"Sometimes we are the recipients of language or behavior from patients that feels demeaning or discriminatory. I would like to take some time as a team to discuss how we are going to respond."
2. Invite resident input	"Sometimes it feels safer if I, as the attending, am the one to address this behavior, However, I want to empower you to act if you prefer. What are your preferences?"
3. Make the plan explicit	"It sounds like the team would like me to step in and address discriminatory behavior and statements. If this occurs, you will notice me saying the following phrase: *'I'm surprised to hear you say that.'*" "It sounds like you all feel comfortable addressing this behavior as it comes up. That is fine, and we can work out the ways to do this. In those situations, I will remain quiet until/unless the patient escalates or the learner signals for help."
4. Obtain an all-in pledge	"I would like us all to commit to protect each other and our environment from the harm of discrimination as much as possible. Can we all agree to that?"

and invite open dialogue if their learners feel that supervisors are contributing to a negative clinical learning environment. Anecdotally, across multiple hospitals at our institution, this first step of reflection is well received by residents, who are grateful for the safe space created for discussion.

Start the conversation about problematic patient behavior in an open-ended manner (TABLE 1). Ask residents how they might respond and how they would like their supervisors to respond—if at all. Microaggressions can occur in the discrepancy between a patient's intentions and a target's perception; therefore, it may not always be appropriate to address a microaggression with a patient. If residents determine that they would appreciate a response, it could happen in the moment, after the encounter, with the patient alone, or with everyone present.

Formal curricula may include implicit bias training, communication skills, and role-playing. These have been shown to empower residents to respond in the moment.[5] Training structures can target a training level. Curricula for residents might involve practicing how to respond to problematic patient behavior directed at interns and students. As this occurs across all levels of training, it is crucial to address the roles within the existing hierarchy of medicine.

Step 2: During the Encounter

An African American resident is discussing a care plan with her patient on the wards with the rest of the medical team in the room. The patient later asks, "Can you step out so I can just talk with my doctors?"

Residents may lack the tools to respond in a way that avoids negative repercussions.[8] Our

TABLE 2
During the Encounter: Reflecting in Action

Principle	Suggested Language
1. Ensure the patient is clinically stable	
2. Address the comment: name the behavior as inappropriate	"I'm surprised you thought that would be an appropriate comment/joke." "Let's keep it professional." "I think you are trying to compliment me, but I am here to focus on your health."
3. Inform the patient you are there to improve his or her health	"I am/we are here to focus on your health."
4. Share your perspective	"When you said XX, I felt YY."
5. (Re)educate the patient about the roles of team members	"Your care team is made up of many different people who are all working to improve your health. I respect every member of your team and ask you to do the same." "Dr. Jones is the physician in charge of your day-to-day care." "Maria is a highly trained nurse who is working hard to provide your daily care."
6. Temporarily remove learners from the setting if behavior continues	"We are going to come back in 30 minutes and hope you will be ready to focus on your health."

TABLE 3
After the Encounter: Reflecting on Action

Principle	Suggested Language
1. Attend to safety and emotions of group	"I would like to take some time to acknowledge and reflect on how that experience felt for everyone."
2. Acknowledge what went well	"I'm hoping you will share a bit about what went well during that encounter."
3. Discuss what could have gone better	"How could we have addressed that situation differently to get a better outcome?"
4. Plan for the future	"I am recommitting myself to keeping the learning environment as safe and positive as possible. Next time something like this happens, I will . . ."

approach (TABLE 2) prioritizes patient care by first assessing the patient's clinical and mental stability before naming inappropriate behavior gracefully, clarifying roles, and (re)establishing respect. As in other stressful situations, practice the steps in a no-risk situation so you are prepared to respond in real-life situations. In our experience, we rarely have to progress past step 2 to redirect the conversation and demonstrate an environment of respect.

When used in a stepwise fashion, patient care is prioritized while respecting learner well-being. Clarifying roles is a significant step of this process. Sometimes residents appreciate when their attendings speak up,[9] while others may appreciate addressing the situation on their own. When a patient behaves inappropriately (assuming the patient is clinically stable), the care of the team can be directed toward the target of the problematic behavior. Business as usual is not an acceptable response.

Step 3: After the Encounter

After returning to the team room, a resident states, "I just don't know how to get patients to take me seriously! It makes me feel inadequate when they call me 'sweetie' or 'honey.' I don't want to go back to the patient's room."

Debriefing is crucial after a patient behaves inappropriately. As suggested in TABLE 3, start by inquiring how the situation felt to the residents. They might think about what felt empowering or disempowering, discover defense mechanisms, or reflect on their response. Faculty can highlight the importance of depersonalizing the event to redirect the team's energy toward the goal of "do no harm."[5] Residents should provide feedback on what could have gone better. Sometimes supervisors do not recognize the problematic behavior or know how to respond, which leads to silence. By reflecting on these situations, negative consequences may be mitigated.

In addition to debriefing, wrap-up sessions after rotations can improve morale and camaraderie. During these sessions, teams can review their patient cases from a biopsychosocial view. This fosters a healing discourse and long-term insight, potentially reducing the likelihood of lasting moral distress.

Conclusion

The patient-physician relationship is nuanced and may require intense reflection in order to promote patient care. Reflection is crucial in preventing burnout. Silence is not an option in the face of problematic patient behavior. We can address discriminatory patient behavior while preserving relationships and promoting outstanding care. Preparing, having a framework to respond in the moment, and reflecting represent significant steps to improve both resident and patient well-being. This 3-step approach can empower everyone to speak up to protect the learning and working environment for residents and encourage a diverse medical workforce that can improve care for future diverse populations.

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