Medical Student Response to Mistreatment by Patients

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Abstract

Purpose: Medical student mistreatment is a pervasive problem in medical education. Recent studies have shown that patients and their families are responsible for a significant portion of reported mistreatment of medical students. This work has not translated into curriculum development in medical schools, and physicians and students express uncertainty with how to address instances of mistreatment by patients. Mistreatment has been shown to negatively impact medical students, particularly female medical students and medical students of color. Grounded in Structuration Theory, the goal of this review is to identify strategies medical students might use to respond to instances of mistreatment by patients to provide recommendations for how students might influence their learning environments. **Method**: In March 2018, a review of health professions literature yielded 21 articles describing strategies for provider response to instances of mistreatment by patients. **Results**: Literature on the topic recommend assertive techniques for discussing instances of mistreatment with the patient and informing the patient that discriminatory behavior is not appropriate in healthcare settings. Recommendations for response to sexual harassment, prejudiced refusals of care, and racist comments by patients are slightly different, with less clear suggestions for addressing racist comments. **Conclusions**: These findings suggest that there are tools medical students might use to address mistreatment by patients, but various types of mistreatment may require different strategies for responding. Future research is needed to determine which strategies are most effective at reducing mistreatment by patients or preventing negative impact on medical students.

Introduction

Mistreatment is defined as "any behavior that shows disrespect for the dignity of others including discrimination based on race, gender, and religion" (Mavis, Sousa, Lipscomb, & Rappley, 2014, p. 705). In 1982, Silver introduced medical student mistreatment as a problem in the medical community and compared its impact on wellbeing to that of child abuse (Silver, 1982). Despite four decades of research and institutional initiatives, mistreatment remains a pervasive issue in undergraduate medical education. A recent meta-analysis reported that mistreatment in undergraduate medical education is common, with 59% of students experiencing mistreatment during training (Fnais et al., 2014).

Trainee mistreatment takes on many forms. Harassment is usually verbal (Crutcher, Szafran, Woloschuk, Chatur, & Hansen, 2011; Fnais et al., 2014). Instances of mistreatment are typically based on the student's age, race and ethnicity, or gender (Crutcher et al., 2011; Fnais et al., 2014). Medical students have also reported work as punishment, academic discrimination, public humiliation, physical abuse, and sexual harassment (Association of American Medical Colleges, 2017; Crutcher et al., 2011; Fnais et al., 2014; Mavis et al., 2014). Some students are at higher risk for experiencing mistreatment, specifically students that are female or nonwhite (Fnais et al., 2014). Mistreatment of medical students is not unique to the United States, as medical educators around the world report similar issues (Coverdale, Gale, Weeks, & Turbott, 2001; Crutcher et al., 2011; Fnais et al., 2014; Rees & Monrouxe, 2011).

Data available on medical student mistreatment focuses heavily on mistreatment from residents and faculty. Much of this data is reported by the Graduation Questionnaire (GQ) administered annually to graduating medical students by the Association of American Medical Colleges. The GQ has surveyed students about experiences of mistreatment during medical

school since 1991 (Mavis et al., 2014). Responses from the 2012 Graduation Questionnaire indicated that medical students were most commonly mistreated by clinical faculty (31%), residents and interns (28%) and nurses (11%) (Mavis et al., 2014). However, the Graduation Questionnaire specifically asks respondents to exclude mistreatment from patients (Association of American Medical Colleges, 2017; Mavis et al., 2014).

While most evidence describes mistreatment of medical students by residents and faculty, recent studies have shown that a significant amount of abuse comes from patients and their families. Researchers have found that patients are responsible for up to 35.2% of the reported mistreatment of trainees in medical school and residency (Crutcher et al., 2011; Fnais et al., 2014). Although research has identified patients and their families as a common source of mistreatment, this work has not translated into curriculum development for medical trainees (Whitgob, Blankenburg, & Bogetz, 2016). In a survey conducted to explore physicians' experiences with prejudiced patients, 85% of physician respondents had not received training on how to address harassment or discrimination from patients (Medscape, 2017). One explanation for this literature gap may be that medical education has yet to identify evidence-based strategies for responding to patients that could be used to develop such a curriculum.

In this capstone, I argue that medical students should receive training on how to respond to instances of mistreatment by patients and their families. I will first present literature to illustrate the scope of mistreatment of physicians and trainees by patients. In subsequent sections, I describe the impact of mistreatment on medical students and review health professions literature to identify strategies to help address patient bias. In the final section, I offer insights based on the findings and consider implications for future curriculum development and research.

Background

Discussion regarding mistreatment from patients and their families is gaining traction in the literature. Recently, several studies have addressed this issue and have suggested that mistreatment of physicians by patients is a common occurrence. In one study the prevalence was remarkably high, with 59% of physicians reporting being subjected to an offensive remark from a patient (Medscape, 2017). Research on mistreatment of physicians and trainees by patients has most extensively reported on experiences of sexual harassment and racial and ethnic discrimination.

Despite the rise in number of female students matriculating into the once male-dominated medical profession, mistreatment research consistently identifies sexual harassment as a problem in medical education. Phillips and Schneider (1993) published a call to action for education and professional development regarding sexual harassment of female physicians, reporting that more than 75% of women physicians had experienced sexual harassment by patients. A survey of graduating medical students' perceptions of patients' sexual behavior by Schulte and Kay (1994) echoed this concern, revealing that 52% of women and 29% of men had experienced inappropriate sexual behavior by patients. Subsequent studies have shown that sexual harassment of physicians and trainees by patients includes sexist slurs, comments about appearance or anatomy, requests to meet outside of work, inappropriate touching, and sexual solicitation (Babaria, Bernheim, & Nunez-Smith, 2011; Phillips & Schneider, 1993; Schulte & Kay, 1994; Shrier et al., 2007).

Race and ethnicity also play a role in mistreatment of physicians by patients. Few studies have quantified the prevalence of racist encounters with patients. One survey found that 19% of physicians were subjected to offensive remarks about their race, while 22% endured comments

about their ethnicity or national origin (Medscape, 2017). There are numerous anecdotal accounts of physicians experiencing racism from patients. These accounts range in severity from surprise that African American students were allowed in Vanderbilt medical school classes (Reddy, 2018) to the more egregious in which a patient asks an Indian American resident "Why don't you go back to India" (Jain, 2013, p. 632). In addition to explicit racism, many medical educators are grappling with how to handle patient requests for different providers grounded in prejudice (Capozzi & Rhodes, 2006; Medscape, 2017; Paul-Emile, 2012; Reynolds, Cowden, Brosco, & Lantos, 2015; Whitgob et al., 2016).

While medical schools are required to have processes in place to report sexual harassment and racial discrimination, most do not offer students guidance on how to address mistreatment in the moment (Medscape, 2017). Trainees and physicians have expressed uncertainty in how to handle these situations. Half of Stanford pediatric residents (Whitgob et al., 2016) and 60% of physician respondents (Medscape, 2017) indicated that they would not know how to respond to a discriminatory patient. Much of the literature regarding mistreatment by patients is prompted by a specific occurrence and published with the intent of generating conversation about how to respond (Jain, 2013; Reynolds et al., 2015; Selby, Neuberger, Easmon, & Gough, 1999; Whitgob et al., 2016). Students participating in Yale School of Medicine's Power Days, a program to challenge power dynamics in medicine, find discussion useful but repeatedly request concrete strategies for addressing these issues in the clinical setting(Angoff, Duncan, Roxas, & Hansen, 2016). In the student section of the British Medical Journal, a third-year medical student in the United Kingdom demands that medical schools teach students how to navigate encounters involving sexual harassment by patients while preserving the student-patient relationship (Brill, 2016). Not only are students requesting education on the

topic; several researchers have also written calls to action to the medical education community to develop curricula that addresses racism and bias and prepares students for challenging patient encounters such as these (Karani et al., 2017; Phillips & Schneider, 1993; Schulte & Kay, 1994).

The position of medical students within the hierarchical structure of medicine and in relation to patients makes them particularly vulnerable to patient mistreatment. Medical ethics require physicians to deliver patient-centered care regardless of a patient's background, putting the patient's interests and well-being first at all times (Paul-Emile, 2012). Students' commitment remain patient-centered may obscure their ability to discern whether it is appropriate to report or intervene in instances of mistreatment from patients. To further complicate the issue, medical students often feel unable to raise concerns with residents and attending physicians due to their influence on evaluations, which students perceive to have great impact on residency applications and future careers (Angoff et al., 2016). Students may not want to risk appearing as though they value their own feelings over those of the patient, which often causes students to remain quiet and endure mistreatment alone.

Mistreatment negatively impacts trainees and is associated with poor mental health, decreased confidence, depression, and increased thoughts of dropping out of medical school (Cook, Arora, Rasinski, Curlin, & Yoon, 2014; Heru, Gagne, & Strong, 2009; Richman, Flaherty, Rospenda, & Christensen, 1992). In addition, these experiences have been shown to negatively impact minoritized students' (e.g., medical students of color, female medical students) professional identity formation, academic performance, and overall wellbeing (Babaria, Abedin, Berg, & Nunez-Smith, 2012; Dyrbye et al., 2007; Karani et al., 2017; Orom, Semalulu, & Underwood, 2013). In an interview with Statnews (Tedeschi, 2017), an associate professor at

Oregon Health and Science University spoke about her experience as an Asian American medical student:

> When it happens to you as a trainee, you tend to think it's your fault on some level… It's like running a race that's super hard. But one person's carrying an invisible heavy boulder on their back. They have to work so much harder.

Hardeman et al. (2015) found that African American medical students who identified most with their race were more likely to have symptoms of depression and anxiety. As national initiatives push to diversify the healthcare workforce, issues of prejudice and discrimination in medical education must also be addressed (Marrast, Zallman, Woolhandler, Bor, & McCormick, 2014; Orom et al., 2013).

Given this problem, I am asking: What is known about strategies medical students might use to address patient bias? In asking this question, I position medical students as the learners while anchoring my work in the context of preclinical medical education. This context is most appropriate for introducing a curriculum on strategies for navigating these experiences because it positions the information in a just-in-time manner, right before students are likely to encounter discrimination in the clinical setting (Phillips & Schneider, 1993; Schulte & Kay, 1994; Whitgob et al., 2016). Furthermore, research has shown that student perceptions of mistreatment change with time. Medical students interpret instances of harassment and discrimination by patients less harshly after clinical rotations than they do before (Babaria et al., 2011; Kulaylat et al., 2017). Some researchers hypothesize that this change in perception may occur because students begin to accept mistreatment as a natural part of medical education during their clinical experiences (Babaria et al., 2011; Kulaylat et al., 2017).

The framing question for this capstone is grounded in structuration theory (Giddens, 1984). Rooted in constructivism, structuration theory posits that social life is impacted by both *structures* and *agents* (Giddens, 1984). *Structures* are components that organize societal environments, such as institutional policies, hierarchical ranking systems, practices and norms, etc. (Giddens, 1984). *Agents* are individuals interacting within social environments (Giddens, 1984). Giddens (1984) describes the relationship between structures and agents as dualistic, with structures influencing how agents may act and agents' interactions shaping, challenging, or maintaining existing structures. Following from this theory, I position medical students and other individuals within the healthcare system as agents and the clinical learning environment as the relevant structure. Structuration theory raises questions about how students might be agents of change within the clinical learning environment. This theoretical framework would suggest that medical students have agency to influence their learning environment by tolerating or challenging mistreatment, a practice which has been long-standing feature of the structure of medical education. In line with this thinking, I chose to review literature that was student- and strategy-focused. In other words, by identifying how students could productively respond to mistreatment by patients, I am clarifying how medical students can improve their learning environment by challenging existing norms, such as the extent to which providers are expected to endure mistreatment by patients.

Methods

I reviewed literature on strategies for response to mistreatment by patients first by conducting an initial search for articles in Google Scholar. These reports were used to identify key search terms related to the patient mistreatment in the provider-patient relationship. Once search terms were identified, I ran separate searches in PubMed, Cumulative Index to Nursing

and Allied Health Literature (CINAHL), and Education Resources Information Center (ERIC). Titles and abstracts of articles were screened for relevance to mistreatment by patients. I manually searched journals that often publish articles related to medical education, such as *Academic Medicine, Teaching and Learning in Medicine,* and *Journal of the National Medical Association.* Additional articles were found by tracing citations using reference lists. Articles were included in the literature review if they offered guidance for providers on responding to instances of mistreatment by patients. Because of limited research published in medical education specifically, I searched for articles from other healthcare training programs, such as physical therapy and nursing. Research on strategies in these fields is appropriate because they have also identified student mistreatment as a problem (Boissonnault, Cambier, Hetzel, & Plack, 2017; Ferns & Meerabeau, 2007; Gleberzon, Statz, & Pym, 2015; Telles-Irvin & Schwartz, 1992; Wheeler, Foster, & Hepburn, 2013; Zook, 2000a). Furthermore, in clinical settings, these professionals are also active members of a patient's care team, and their work requires a provider-patient relationship that is similar to physicians'.

Results

21 articles discussing strategies to respond to instances of mistreatment from patients were identified and included in the literature review. Of these 21 articles, nine were research reports, eight were perspectives, three were literature reviews, and one was a medical ethics opinion. Eight focused on sexual harassment, eight discussed refusal of care based on prejudice towards race, ethnicity, or gender, four dealt with explicit racism, and one reported on ethical implications of discriminatory patient behavior. Some articles offered further guidance on educating students about mistreatment by patients.

Three themes emerged from literature regarding strategies to respond to inappropriate sexual behavior: ways that female providers prevent sexual harassment from patients, their most common responses, and recommended strategies for responding. One of the earliest studies investigating sexual harassment of female physicians conducted a survey in which respondents provided suggestions for preventing sexual harassment by patients (Phillips & Schneider, 1993). Respondents recommendations included female physicians altering their dress by buttoning their lab coats, assuming a distant, professional demeanor with male patients, and increasing office security (Phillips & Schneider, 1993). Though these recommendations are seemingly outdated, a more recent study of female medical students' experiences throughout clinical rotations revealed that students often adopted these methods of avoiding awkward encounters with male patients (Babaria et al., 2012). In contrast, other researchers argue that sexual harassment of providers by patients is unavoidable (Cambrier, 2013).

Self-reported data on providers' experiences indicate that most providers continue to care for the patient despite being subjected to inappropriate sexual behavior (Phillips & Schneider, 1993; Telles-Irvin & Schwartz, 1992). Telles-Irvin and Schwartz (1992) polled dentists and dental students in Texas about reasons for tolerating sexual harassment from patients. The majority of students and dentists were optimistic that the patient would discontinue the behavior (Telles-Irvin & Schwartz, 1992). Both Phillips and Schneider (1993) and Telles-Irvin and Schwartz (1992) found that some providers felt that they did not have the option to terminate care based on patient behavior.

Providers who are sexually harassed by patients most often ignore the behavior (Babaria et al., 2012; Cambrier, 2013; Telles-Irvin & Schwartz, 1992). Babaria and colleagues (2012) reported that some female medical students in clerkships reported dismissing sexual harassment

from patients by focusing on the fact that they would not have care for the patient long-term. However, this group of participants also expressed disappointment that their female mentors recommended "just dealing with it" (Babaria et al., 2012, p. 1016). In her position paper on addressing inappropriate patient sexual behavior in physical therapy education, Cambrier (2013) argues that ignoring sexual harassment may communicate to patients that inappropriate sexual behavior is allowed which may result in a worsening of the behavior.

Another common response to sexual harassment by patients is avoidance (Cambrier, 2013; Zook, 2000a). Avoiding the patient's behavior may look like making conversations or treatment with patients more public, spending less time with the patient, refraining from engaging emotionally, or physically distancing oneself from the patient (Cambrier, 2013). Cambrier (2013) does not recommend this strategy to rising physical therapists, because although it may limit the provider's exposure to sexual harassment, it may also reduce the quality of patient care. Less common strategies were reported by dental students and dentists and varied by situation, such as instructing the patient to stop, making light of the situation with a joke, documenting the incident, or verbal retaliation (Telles-Irvin & Schwartz, 1992).

Being assertive when subjected to sexual harassment by patients was the most highly recommended strategy in health professions literature (Cambrier, 2013; McComas, Kaplan, & Giacomin, 1995; Zook, 2000a). Zook (2000a) developed a workshop that taught nurses to respond to inappropriate patient sexual behavior using a four-step process: self-reflection on emotions and reactions to the incident, notice patient defense mechanisms, respond assertively, and establish clear boundaries with consequences. Zook (2000a) and Cambrier (2013) both offer specific techniques for responding assertively that could be rehearsed. For example, providers might use an "I think, I feel, I want" statement to describe the issue, share their feelings, and

establish boundaries for behavior (Cambrier, 2013; Zook, 2000a). Another strategy, referred to as active listening and broken record, avoids argument by using a repetitive statement in combination with letting the patient know they are being heard (Cambrier, 2013). For example, "I hear that you think I'm being uptight, and I need you to stop commenting on my body" (Cambrier, 2013, p. 12). For more abusive behavior, the authors suggest clearly stating boundaries and providing positive behavior alternatives and enforceable consequences for persistent negative behavior (Cambrier, 2013; Zook, 2000a).

Lastly, McComas et al. (1995) and Cambrier (2013) recommend documentation of sexual harassment by patients. This information could be reported to training program directors, hospital administration, or recorded in the patient's health record. McComas et al. (1995) advocates for record-keeping of inappropriate sexual behavior to serve as rationale for termination of the provider-patient relationship and as a caution to future healthcare professionals working with that patient.

Many authors discussing strategies for responding to sexual harassment by patients argued that training programs need to address sexual harassment within the curriculum (Boissonnault et al., 2017; Cambrier, 2013; McComas et al., 1995; Phillips & Schneider, 1993; Telles-Irvin & Schwartz, 1992). Several recommendations were made about topics that should be included in curricular content. All researchers discussing educational content mentioned the need for training programs to provide general information about sexual harassment, such as definitions, prevalence, risk factors, and provider rights (Boissonnault et al., 2017; Cambrier, 2013; McComas et al., 1995; Phillips & Schneider, 1993; Telles-Irvin & Schwartz, 1992). Furthermore, curricular content on prevention (McComas et al., 1995; Telles-Irvin & Schwartz, 1992), response strategies (Cambrier, 2013; McComas et al., 1995; Telles-Irvin & Schwartz,

1992), methods of documentation (Boissonnault et al., 2017; Cambrier, 2013), and transferring or discontinuing care (Boissonnault et al., 2017) was also requested.

Trainees, hospital administration, and medical educators are also grappling with how to respond when patients refuse care based on prejudice toward a student or provider's personal background. For example, how should a provider respond to a parent telling a pediatric resident that she cannot examine a child because she is not white (Reynolds et al., 2015) or a patient requesting to be referred to a physician who is not of a certain ethnicity (Baraitser, 2006)? One article presented a heavily debated scenario, in which a female patient refused to let a male medical student participate in a routine gynecologic exam (Peek, Lo, & Fernández, 2017). These challenging encounters are not uncommon. Nearly half of physicians indicate that a patient has refused their care or requested a different referral because of personal characteristics (Medscape, 2017). The authors of this study reported that over two-thirds of these physicians chose to accommodate the request (Medscape, 2017). Prejudiced refusals of care by patients may occur more frequently among providers from minority groups. Nunez-Smith et al. (2009) found that 60% of non-Hispanic black physicians had patients refuse their care.

Addressing biased refusals of care by patients is a complicated ethical dilemma. Providers must balance patient needs and workplace rights in a context with a long history of discrimination against racial and ethnic minority groups. Accommodating prejudiced requests may qualify as workplace discrimination, reinforce negative stereotypes, and communicate to patients that this behavior is acceptable in healthcare settings (Paul-Emile, 2012; Reynolds et al., 2015). However, ethical principles support the obligation to honor patient autonomy (Paul-Emile, 2012; Reynolds et al., 2015). In a review of pertinent law and medical ethics, Paul-Emile

(2012) outlines the need for the creation of policy to guide providers on addressing race-based requests.

Recent work on refusal of care by patients has led to the development of an algorithm to guide healthcare administration and staff responses (Paul-Emile, Smith, Lo, & Fernández, 2016). This algorithm leads users through a series of decision points based on the patient's health status, decisional capacity, and reasons for requesting an alternate provider. Based on the algorithm, a competent and medically stable patient's request does not have to be accommodated if it is grounded in racial bias. Regardless of the decision made, Paul-Emile et al. (2016) argue that patients should be made aware that prejudiced opinions are incongruent with beliefs of the medical profession and unacceptable in the healthcare setting.

There is a paucity of empirical research data regarding effective strategies for response to biased refusal of care by patients. Whitgob and collegeaus (2016) conducted the only known qualitative study using case scenarios to determine how teaching faculty in a pediatric residency program would respond to patients refusing care based on prejudice both as a resident and an attending physician. Similar to the algorithm by Paul-Emile et al. (2016), faculty suggested that trainees first assess the patient's medical status (Whitgob et al., 2016). Unstable patients requesting an alternate provider require treatment immediately and should not be accommodated (Paul-Emile et al., 2016; Whitgob et al., 2016). Faculty offered specific recommendations on how to communicate with patients about their reasons for refusal and suggested that empathetic conversation may strengthen the provider-patient relationship (Whitgob et al., 2016). Lastly, faculty emphasized the importance of debriefing with trainees to depersonalize any abusive remarks and allow trainees to decide for themselves whether they would like to continue caring for the patient (Whitgob et al., 2016).

Several healthcare professionals, along with ethicists, lawyers, and administrative staff, were prompted by an incident to publish opinions about responding to prejudiced refusals of care by patients (Baraitser, 2006; Capozzi & Rhodes, 2006; Reynolds et al., 2015). Almost all collaborators agreed that informing the patient about unacceptable behaviors is necessary. However, there were differing opinions regarding whether providers should accommodate biased requests. Advocates for accommodation argued that patient needs come first (Baraitser, 2006; Peek et al., 2017; Reynolds et al., 2015), while critics stated that medical centers are not required to offer patients options (Capozzi & Rhodes, 2006), enduring racism is not an issue of professionalism (Reynolds et al., 2015), and stable patients have the option to seek care elsewhere (Capozzi & Rhodes, 2006; Reynolds et al., 2015). One physician uniquely introduced stereotype threat as a negative consequence for patient care in situations where trainees are required to continue working with prejudiced patients (Reynolds et al., 2015). Overall, the majority of literature suggests that discriminatory behavior by patients should not be tolerated, students should be supported, and decisions about accommodating biased refusals of care should depend on the situation.

Review of the literature yielded less specific guidance for providers on responding to racist comments by patients. Berdes and Eckert (2001) interviewed thirty nurse's aides in nursing home settings and reported that nurse's aides' responses were impacted by their interpretation of the motivation behind patients' racist remarks. When patients used language from the past no longer considered socially acceptable, nurse's aides often dismissed the behavior as due to factors such as the patient's age and personal experience or gently corrected use of inappropriate language (Berdes & Eckert, 2001). Berdes and Eckert (2001) designated this type of encounter as "anachronistic racism" (p 114). However, when patients of sound mind used racist language

seemingly to offend, nurse's aides again ignored the behavior, addressed the issue with the patient, or avoided interaction with the patient (Berdes & Eckert, 2001). Other researchers studying nurses' experiences of racism in nursing homes described the use of similar coping strategies (Milburn & Stephenson, 2012; Wheeler et al., 2013).

One study (Milburn & Stephenson, 2012) provided a more nuanced understanding by sorting strategies for responding to racist comments by patients into active or avoidant and cognitive or behavioral (Billings & Moos, 1981). Active strategies are those in which the nurse intends to affect the outcome of a thought or interaction (Billings & Moos, 1981). In contrast, strategies in which the nurse remains passive are referred to as avoidant (Billings & Moos, 1981). Behaviors are further categorized as behavioral, meaning the nurse engaged in an action, or cognitive, meaning the nurse framed thoughts in a certain way (Billings & Moos, 1981). For example, documenting a patient's racist comments would be considered an active behavioral strategy, while choosing to avoid thinking of the comments would be considered an avoidant cognitive strategy (Billings & Moos, 1981). Although no definitive strategy exists for providers to respond to racist comments by patients, Berdes and Eckert (2001) argued that "productive confrontation" may be the best strategy (p 125).

The literature on strategies for provider response to instances of mistreatment by patients does not offer a concise blanket recommendation for all types of discriminatory patient behavior. However, the American Medical Association Code of Ethics may provide some guidance. Opinion 1.2.2 states that the patient-physician relationship requires trust and respect from both parties (Chaet, 2017). Therefore, physicians have the right to transfer a patient's care to another physician if the patient "uses derogatory language or acts in a prejudicial manner" (Chaet, 2017).

Opinion 1.2.2 clarifies that physicians have this right only in cases where the patient does not change or stop the offensive behavior (Chaet, 2017).

Discussion

Literature on strategies for medical students to respond to instances of mistreatment by patients focused on sexual harassment, prejudiced refusals of care, and explicit racism. Recommended responses to mistreatment by patients in all three types of the scenarios discussed were similar. Taking an assertive approach with the patient about the unacceptable behavior was most advocated for. This approach involves identifying and explaining to the patient which behaviors are inappropriate. Although assertiveness was deemed the best strategy, studies that explored providers' self-reported responses to mistreatment by patients revealed that most providers ignored or avoided the patient's discriminatory behavior.

Literature on sexual harassment of providers by patients yielded concrete and detailed strategies for response to inappropriate patient sexual behavior. These strategies incorporate multiple steps: discussing the inappropriate behavior with the patient, setting boundaries, and providing enforceable consequences. Similarly, authors discussing ways of responding to prejudiced refusal of care by patients recommended a stepwise approach to assessing the patient's health status and decisional capacity, inquiring about the patient's reasons for refusal, and making a decision about accommodation of the request. Ensuring safety of the trainee by debriefing the incident, depersonalizing the event, and giving the trainee the choice about whether to continue working with the discriminatory patient was also suggested. In contrast, less information is available about best practices for responding to racist comments by patients. One article advised providers to address the issue with the patient directly. However, providers reported using different strategies for response depending on the situation. Ultimately, the

American Medical Association Code of Ethics grants physicians the right to terminate care if a patient exhibits persistent discriminatory behavior toward the physician.

In this capstone, I have argued that medical students should receive training on how to respond to instances of mistreatment by patients and their families. This work adds to existing research in the field of medical education by highlighting ways in which medical students can exercise agency and influence their clinical learning environment, specifically by identifying strategies for response to mistreatment by patients. The strategies identified in the review of the literature could be used to inform the development of a curriculum for training medical students on mistreatment by patients.

Providing medical students with tools to productively respond to mistreatment by patients may have a number of benefits. Engaging students in discussion about experiences with mistreatment by patients might help students realize that these experiences are common and decrease self-blame (Phillips & Schneider, 1993). Although education will not protect students from mistreatment by patients, teaching students strategies to respond to discriminatory patient behavior may prevent negative psychological effects of mistreatment (Boissonnault et al., 2017). In addition, because minoritized groups are at higher risk for mistreatment by patients, this literature review contributes to work aiming to design clinical learning environments that support minoritized students.

Although a greater volume of research on responding to prejudice exists in other disciplines, the scope of the present review was limited to health professions education literature to capture the context of a provider-patient relationship. The method of searching for identify articles was another limitation of the review. No standard language for discussing mistreatment by patients exists. The search terms used may not have captured the many ways that authors

discussed mistreatment by patients and, therefore, relevant articles may have been excluded. Furthermore, several of the articles reviewed were published in countries other than the United States which may have differing cultural perspectives regarding mistreatment in medical education and the patient-provider relationship.

More work is needed to inform the development of a curriculum for medical students on mistreatment by patients. Educators should determine what policies regarding discriminatory patient behavior exist at their institutions and include these in curricular content, as policies serve as components of structures that impact agents' ability to act within a context (Giddens, 1984). Such policies may constrain students' options for responding to mistreatment by patients. In addition, the efficacy of strategies for response to mistreatment by patients is unknown. Research in this area is needed to determine which strategies would be most useful to include in a curriculum for medical students.

A review of literature on strategies for response to mistreatment by patients generated ideas about possible design considerations for a curriculum on mistreatment of medical students by patients. The content of the curriculum might be best split into two sessions. Students could prepare for the first session by reviewing material on the prevalence and types of mistreatment by patients (Zook, 2000b). During that session, students would have the opportunity to share and discuss their experiences if they felt comfortable (Angoff et al., 2016; Zook, 2000b). Particular attention would be paid to students' feelings about the situation and reactions toward the patient (Zook, 2000b) to facilitate discussion about possible impacts on the student and patient care. Finally, students would use role-play in groups using case scenarios to practice responding to mistreatment by patients and to receive feedback from peers (Zook, 2000b). The second session might consist of a simulated case scenario with a patient actor, in which students would

experience an instance of mistreatment by the patient and choose if and how to respond (Cambrier, 2013). These activities would give students practice responding to instances of mistreatment by patients in a safe environment and reflecting on challenging encounters (Cambrier, 2013).

Conclusions and Future Study

Mistreatment of physicians and trainees by patients is common. Research has shown that mistreatment negatively impacts medical students, particularly students from minoritized groups. As medical education seeks to diversify the nation's healthcare workforce, issues of harassment and discrimination need to be addressed. Medical schools do not offer guidance on how students should respond to mistreatment by patients, and students and physicians often do not know how to navigate these situations. Educators should include strategies for medical students to respond to mistreatment by patients within the medical school curriculum. A review of health professions literature was conducted to identify strategies medical students might use to respond to mistreatment by patients. Literature on the topic focused on sexual harassment, prejudiced refusal of care, and racist comments by patients. Sexual harassment literature recommended assertive strategies for responding that incorporate discussing the inappropriate behavior with the patient, establishing boundaries, and outlining enforceable consequences for persistent inappropriate behavior. Prejudiced refusal of care literature presented a stepwise strategy for individuals to decide whether to accommodate patients' requests for alternate physicians. This strategy was paired with informing the patient that discriminatory behavior is not appropriate in healthcare settings. Literature on provider response to racist comments by patients yielded less clear recommendations but revealed that providers often use different strategies depending on the encounter. These findings suggest that there are tools medical students might use to address

mistreatment by patients, but various types of mistreatment may require different response strategies.

Future research is needed to determine whether increasing diversity of medical school classes paired with growing emphasis on patient-centered care has any impact on prevalence of mistreatment of providers by patients. More work investigating how medical students and physicians respond to instances of mistreatment by patients, specifically sexual harassment and racism, is needed, as the majority of work in these areas came from nursing and physical therapy literature. A more nuanced understanding of the situations in which medical students use different strategies for responding to mistreatment by patients is necessary to determine if teaching should focus on situation-dependent methods or methods for more general application. Assessing the efficacy of response strategies with respect to reduction of inappropriate patient behavior or prevention of adverse psychological effects would help medical educators identify which strategies would be most useful to include in a curriculum for medical students. More broadly, additional data on mistreatment of medical students by patients would provide valuable insight on students' experiences in medical training and may uncover other avenues for intervention.

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