5 Physician Experience: Impact of Discrimination on Physician Wellness

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The Physician Experience of Discrimination

Practicing as a resident physician is not easy. This may have been expected upon entering medical school with its combination of long hours, high expectations, and intense competition, proving sometimes to be an exercise in survival. Perhaps what may not

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have been expected though are the numerous other insults to physician wellness that are less often talked about or addressed. These are macro- and microaggressions, the experiences of discrimination based on age, gender, race, religion, disability, and sexual orientation. While not unique to physicians, such bias and discrimination unfortunately impact many physicians' careers and lives, negatively affecting the health and wellness of both trainees and physicians in practice.

In 2018, the Canadian Medical Association (CMA) conducted a national survey of physicians to better elucidate intrinsic and extrinsic indicators of health and wellness among Canadian physicians. Of the 2947 residents and practicing physicians who completed the survey, 30% of participants experienced high burnout and 9% reported a sense of low well-being [1]. Furthermore, one third of respondents screened positive for depression [1]. Results of the survey showed that women and resident physicians had higher odds of experiencing both burnout and depression (OR 1.32 and 1.95, respectively). In addition, physicians in their first 5 years of practice had 1.74 higher odds of having suicidal ideation in the past 12 months [1]. Interestingly, emotional, social, and psychological well-being were found to be significantly higher in physicians practicing for 31 years or more [1]. Despite the high prevalence of burnout and depression, only 15% of all respondents identified having accessed a Physician Health Program in the past 5 years. Shame was one of the top reported barriers to seeking help [1]. It would be interesting for researchers to explore and clarify factors contributing to female physicians' higher prevalence of burnout compared to their male counterparts, as well as those contributing to early career physicians' risk of decreased well-being compared to more established physicians. Until recent decades, medicine has been a male-dominated professional field. Since many graduating medical classes are now predominantly female, and since female physicians more frequently report burnout, some have speculated that outdated historical societal roles and expectations of women (related to home and career) may contribute, at least in part, to this discrepancy [2].

The results of the 2018 CMA survey highlight how certain physician populations may be more susceptible to burnout and a languishing sense of well-being. While there are likely many factors contributing to this, this chapter will explore how experiences of discrimination based on race, age, gender, sexuality, and disability may negatively impact physician wellness and will emphasize the importance of acknowledging and eliminating discrimination while promoting diversity and equality in medicine.

Skill-Building Exercise: Pause and Reflect

- When have you encountered discrimination in the workplace?
- What thoughts and emotions did this provoke?
- What impact did this have on your own sense of psychological safety and wellness?

Consider how you responded to this experience. In retrospect, are there any ways in which you would have responded differently? Self-reflection allows for the opportunity to better understand the impacts of discrimination on one's own sense of well-being. Debriefing with a supportive colleague may also be helpful in coping with and learning from these experiences.

Cultural Safety and the Physician: Microaggressions and Beyond

There is appropriately an increasing emphasis on training physicians to be culturally sensitive; for example, Canada has recently implemented mandatory cultural safety training for all resident trainees [3, 4]. Similarly, the accrediting body for US medical schools requires that medical trainees attain a specified level of cultural competence by the end of training; as such, assessment

tools have been designed to ensure that the standards for cultural competence curricula are met [5]. Cultural safety speaks to the importance of developing a relationship of trust between patient and physician, one that is respectful of diversity and of an individual's uniqueness and value [6]. This is therefore an essential competency of a physician. It is of utmost importance that physicians continue to advocate for culturally safe patient care on both an individual and organizational level. At the same time, physicians themselves represent culturally diverse backgrounds, yet unfortunately may not experience a sense of cultural safety in their own work environments.

Did You Know?

Microaggressions are defined as the everyday biases that communicate a derogatory or hostile message to ward members of a marginalized group [7]. These can be intentional or unintentional slights in the form of words or behavior. Examples of microaggressions include commenting on an individuals' good command of the English language because they are a visible minority or assuming that someone is a nurse because she is a woman.

Many instances of physicians experiencing discrimination based on race have been described on physician forums and in the media [8–10]. Because physicians have committed to professionalism and healing in their work, it can be ethically challenging when patients express a preference to be treated by a *different* physician – one with a different skin color, accent, or religion. Moreover, such overt signs of racial and cultural bias can understandably activate an overwhelming sense of invalidation for a physician who has worked many years to achieve their level of knowledge and skill [11]. As described by one physician on their experience of racism in medicine: "Racism stripped me of my white coat, my stethoscope, my doctor's badge, my degrees and credentials, my titles, my skills, and my determination to serve" [8]. Notably, the Oxford online dictionary defines *racism* as the "prejudice, discrimination, or antagonism directed against a person or people on the basis of their

membership of a particular racial or ethnic group, typically one that is a minority or marginalized" [Racism. (2020). In Oxford Online Dictionary. lexico.com/definition/racism].

Physicians have described the profound shift in power they perceive because of racial bias, feeling the need to prove their capabilities, to prove that they are not an "imposter" [8]. This may be particularly evident among medical trainees, who already may perceive a sense of powerlessness. In addition to these overt signs of discrimination, more subtle microaggressions may also be a regular part of the physician experience, as exemplified by one physician's description:

> "A raised eyebrow suggests there is surprise or a question about my ability. A 'good for you' is an unexpected affirmation of my credentials as a physician, as if it were impossible for a black woman to achieve this level of training". [12]

The cumulative effects of these experiences can contribute to psychological distress and physician burnout [3, 13]. Beyond clinical interactions with patients, studies have shown that minority physicians may also have fewer opportunities for career advancement and may be underrepresented in leadership positions [9, 14]. To help address this, it has been proposed that medical regulators take a role in addressing racism with anti-abuse policies and by providing physicians with guidance on how to manage experiences of racism in the work environment [10]. As experiences of racial bias may be met with silence out of fear of consequences for speaking out, it is essential that physicians be empowered and feel supported in prioritizing and addressing these concerns related to workplace culture at both individual and systemic levels.

Honoring the Voice of Indigenous Physicians: The Canadian Experience

Indigenous physicians have historically accounted for a small minority of practitioners, and important initiatives within the last two decades are working to address this in Canada. In recognition

of the distinct health needs of Métis, Inuit, and both on-and off-reserve Indigenous peoples, The Truth and Reconciliation Commission of Canada (TRC) 2015 final report called on all levels of government to: (i) increase the number of Indigenous professionals working in the healthcare field, (ii) ensure retention of these healthcare providers in Indigenous communities, and (iii) provide cultural competency training to all Canadian healthcare workers [15]. Indeed, in response to self-advocacy and decolonizing efforts across Canada, this report also called on the Canadian healthcare system to recognize the value of traditional Indigenous healing practices and ways of knowing, and to utilize these therapies alongside Western medicine and in collaboration with Indigenous healers and Elders where requested by patients [15].

Now 5 years post-TRC publication, positive strides have been made, yet a significant health disparity still exists between Indigenous and non-Indigenous Canadians [15]. Despite comprising 4.9% of the Canadian population, Indigenous people are believed to represent less than 1% (760 vs. 93,985) of practicing physicians [16]. It is encouraging that this number has doubled over the past decade, with an approximated number of 200 Indigenous physicians practicing in 2008 [17]. This slow increase in numbers may also be due in part to the 2005 Kelowna Accord, which set a target to double Indigenous physicians in the following decade [18]. This historic deal was preceded by a 2004 announcement from the Aboriginal Human Resources Initiative, which, in addition to the recommendations reiterated in the TRC's 2015 final report, supported three areas of focus: adapting healthcare curriculum to support cultural competencies, increasing the number of Indigenous physicians, and increasing retention of healthcare workers in Indigenous communities [19]. To further recognize the specific expertise of First Nations, Inuit, and Metis physicians, as well as their right to self-determination, the Indigenous Physicians Association of Canada and the Association of Faculties of Medicine of Canada signed a joint agreement to establish admission support programs to prospective Indigenous medical students, including pre-admission toolkits, and to promote recruitment and retention of mature Indigenous students [17].

Despite the implementation of these policies, grants, and initiatives, the road to becoming a physician is ripe with obstacles for many prospective Indigenous students, at times including lack of generational wealth, systemic barriers, overt racism, ripping from traditional lands and supports to attend urban-based schooling, and lack of professional role modelling and Indigenous-led mentorship [20]. Literature qualifying these specific struggles is sparse, with authorship from Indigenous healthcare workers even sparser. Legacies of colonization, intergenerational trauma, power imbalance, and policies perpetuating institutional racism create substantial obstacles to individuals as they strive to contribute as future Indigenous physicians, scholars, and community leaders. As well, current competitive healthcare and educational frameworks can create ongoing challenges for Indigenous medical students and residents navigating their future career goals [21, 22]. In 2013, the Royal College of Physicians and Surgeons of Canada formally identified the importance of cultural safety and self-reflection as integral competencies for Canadian practitioners as effective communicators, collaborators, and medical experts [23], with many residency programs across North America requiring learners to engage in Indigenous health and cultural safety training [4, 5, 10].

On the journey towards reconciliation, Canadian physicians are called to be advocates and allies with their Indigenous peers and patients, supporting growth and inclusion of Indigenous medical students and residents, calling out racism in communities and in the workplace, by honoring Indigenous expertise, and by creating space for Indigenous leadership [15, 21, 22].

Skill-Building Exercise: On Experiences and Allyship

The Anti-Oppression Network of Canada defines *allyship* as the "active, consistent, and arduous practice of unlearning and re-evaluating, in which a person in a position of privilege and power seeks to operate in solidarity with a marginalized group" [24]. Physicians, by virtue of profession and place in society, are called to be advocates and allies on behalf of their patients. This calling is further emphasized by the roles of

Communicator, Collaborator, and *Health Advocate* within the CanMEDS Competency Framework, but does not explicitly make reference to the duty of allyship to physician peers. The authors challenge the reader to consider how they can be better team members and advocates for both themselves and colleagues affected by bias and discrimination [25]. Notably, the Oxford online dictionary defines *bias* as the "inclination or prejudice for or against one person or group, especially in a way considered to be unfair" [Bias. (2020). In Oxford Online Dictionary. lexico.com/definition/bias]. *Discrimination* is "the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, or sex" [Discrimination. (2020). In Oxford Online Dictionary. lexico.com/definition/discrimination].

Reflection questions:

1. Do you identify as an Indigenous or visible minority physician? Have you or any of your colleagues experienced any of the challenges discussed in this chapter? What factors do you believe contribute to these challenges? Conversely, what supports and protective factors contribute to your personal and professional wellness?
2. Think about a time you engaged with an Indigenous patient who valued traditional healing practices and medicines. What impact did you think these methods had on your patient's healing? What did you learn from these encounters?
3. Reflect on your own thoughts, feelings, and questions related to clinical experiences incorporating traditional medicines, healers, and/or Elders into your patients' care. What did these interactions evoke?
4. What changes to your daily practice are needed to provide culturally safe and inclusive care to all patients? What steps can you take to be a better physician ally with your colleagues who experience discrimination and racism?

Ageism and the Physician: "You're Too Young to Be a Doctor"

At some point during their medical career, and often in residency, many physicians hear a patient comment, "You're too young to be a doctor." While such a comment may be considered benign or even complimentary from the patient's perspective, the physician may perceive the meaning to be, "You're too young to be *my* doctor." This passing comment can then hold significant meaning for the physician if the perception is that the patient is not confident in the care that is being provided to them. While there is a dearth of published literature on this topic, it can be argued that such comments may contribute to a sense of invalidation and imposter syndrome for some physicians. Similarly, patients have been known to request "the real doctor," which can be interpreted at times as distrust in the resident physician's abilities and care.

On the other end of the age spectrum, there has been some debate in the published literature and the media about the clinical safety of older practicing physicians, especially those beyond the average age of retirement. In the USA, the largest age distribution of practicing physicians (29%) in 2018 was between 55 and 65 years old [26]. While the average age of physicians in Canada was close to 50 years old in 2018, this is expected to rise in coming years and it is estimated that 20% of Canadian physicians will be 65 years or older by the year 2026 [27, 28]. Approaching retirement can be a time of profound change for physicians. Not only does the physician need to consider and balance financial obligations, workload, and a sense of responsibility to one's patients, but work is also likely to have become a significant part of one's identity [29].

The question has been asked time and time again: should older physicians be "required/mandated" to retire at a certain age? Several studies have demonstrated the association between aging and decline in cognitive abilities such as processing speed and visuospatial ability and, as a result, some speculate that cognitive evaluations of older physicians may be warranted [30]. However, older physicians can also offer extensive clinical knowledge and experience and may continue to perform at or above the same

level as their younger colleagues [31]. Overall, it is likely that the effect of age on a physician's competence is highly variable [30, 32]. Using older age as the sole determinant of when a physician should lay down their stethoscope or scalpel can thus be conceived as a form of discrimination, no different than making negative assumptions about a physician's level of competence based on their youthful appearance. Rather than making assumptions, it has been recommended that older physicians might consider making a habit of regularly seeking out feedback on performance from peers and listening carefully to any concerns expressed by others [32].

Harassment and Discrimination Among Medical Trainees

A well-researched topic in academic literature is that of harassment and discrimination among healthcare professionals including medical trainees. It is well-known that mistreatment of medical trainees contributes to the high rates of burnout and mental health concerns that are experienced by this population [33, 34]. A 2014 meta-analysis of 51 studies showed that 59.4% of medical trainees experienced some form of harassment or discrimination on at least one occasion over the course of their medical training [34]. Verbal harassment was found to be the most common form of abuse, with consultants being the most commonly cited source of harassment and discrimination [34]. Given that supervisors are in a position of superiority and that learners might fear negative professional consequences for speaking out, it can be difficult for learners to report experiences of harassment and abuse. Reporting policies and processes that are clear and reliably enforced are imperative if this issue is to be successfully addressed in medical education [34, 35].

Sexual harassment frequently affects both female and male physicians during their careers and is important among the discrimination experiences and burnout of physicians. Although some recent data reported high rates of sexual harassment in both women and men [36], consistent research findings have established

that sexual harassment is a much larger problem for female physicians than for male physicians and emphasized the influence that sexual harassment has on women in medicine [36]. In a 2014 survey of US academic faculty, 30% of women reported having experienced workplace sexual harassment [37]. Among women reporting harassment, 59% reported that these experiences negatively affected their confidence as professionals, and 47% reported a negative impact on their career advancement [37]. Furthermore, Jenner and colleagues have recently shown that strong institutional hierarchies in medicine were associated with sexual harassment in both sexes [36]. The authors call for a cultural shift in the medical hierarchy in the form of structural and widespread action to address and mitigate risk of sexual harassment in academic medicine [36].

Reporting sexual harassment can be taxing and risky, even in the current #MeToo era; those who report sexual harassment may experience stigmatization, marginalization, or retaliation [38]. This can lead to chronic stress and burnout for those affected. During medical training, false accusations of sexual harassment and abuse are believed to be uncommon and medical trainees have a lot at stake in reporting abuse. Supporting those affected by any kind of harassment, including sexual type, from marginalization and retaliation is of utmost importance. If a medical trainee is being harassed at work, Table 5.1 summarizes general tips on what to do and where to go for help [39].

In addition, sexual harassment of physicians by patients deserves special attention due to its high frequency and complexity [40]. A recent study has shown that nearly one-third of physicians reported being sexually harassed by a patient [36]. This can lead to significant negative consequences that affect both the physician and the patient's care [40]. Further research to investigate the prevalence of patient-initiated sexual harassment is warranted. Formal processes for reporting patient-initiated sexual harassment and addressing it in medical settings are greatly needed. For example, Viglianti and colleagues have suggested a useful algorithm to guide medical trainees and practicing physicians in balancing their obligation to provide care with their need to work in a safe environment [41]. The key question

Table 5.1 Tips for medical trainees experiencing workplace harassment [39]

Incidents or complaints of workplace harassment should be reported right away to your supervisor or person designated by your postgraduate education office (sometimes the program director or rotation coordinator)
Prepare and keep a written record of: When/where you were harassed What was said/done Who said/did it Names of any witnesses
If you have been a victim of a criminal offence (e.g., physical assault, sexual assault, stalking), you should call the police
Seek out a peer/person at your workplace who can provide confidential support
Access local support organizations and learn about relevant local laws; e.g., one can contact the Ministry of Labour in Ontario about a workplace harassment complaint if the employer fails to conduct an investigation that is appropriate to the circumstances
In Ontario, the Assaulted Women's Helpline (http://www.awhl.org/contact-us) offers a 24-hour telephone service to provide counselling, emotional support, information, and referrals to women who have experienced harassment and/or abuse. (Data from Ontario Ministry of Labour: https://www.labour.gov.on.ca/english/hs/pubs/fs_wvh_atwork.php)
All academic institutions have harassment/abuse policies, procedures, and guidelines, including how a medical trainee can access confidential support to discuss a concern or make a formal complaint; e.g., at McMaster University in Hamilton, Canada, there is the policy Discrimination and Harassment: Prevention & Response (https://www.mcmaster.ca/respectfulcommunity/), a resource for anyone who wishes to discuss a discrimination or harassment concern, to schedule an educational presentation, or to request materials

in this algorithm for a medical trainee or a practicing physician is, "Do you feel safe?" If one feels safe, the patient's behavior needs to be clearly and promptly addressed [41]. If feeling unsafe, the medical trainee or practicing physician has the right to excuse themself from the patient encounter as promptly and safely as possible, while seeking help from a colleague and/or supervisor [41]. All such instances of sexual harassment should be reported to the appropriate leadership [41]. At the physician's discretion, the patient's care can be transferred to a

different physician, in keeping with most institutions' obligation to support the decision of the physician while caring for the patient [41].

On Being a Woman in Medicine

Female physicians, residents, and medical students continue to suffer from gender-based intimidation, discrimination, harassment, and perceived role expectations that negatively impact their residency applications, educational experience, hiring, financial remuneration, career trajectory, leadership opportunities, and personal wellness [42–48]. To state it clearly, the Canadian Human Rights Commission defines harassment as any unwelcome threats, comments, jokes about one's identifying factors, or any form of unwelcome physical contact [49].

For the first time in recent history, women and men are graduating from medical school at the same rate [50]. Despite this 1:1 ratio, female physicians continue to be under-represented at many levels of leadership and are less likely to receive promotions [50, 51]. For example, female physicians are less likely to be full professors, are more likely to be assistant professors, and are less likely to be engaged in high-level management and institutional leadership roles [51]. In exploring potential barriers to career advancement, female physicians are more likely to cite challenges with work-life balance, child rearing, workplace harassment, and lack of female mentorship as factors complicating their career development and impeding their ability to pursue and obtain leadership roles [50]. Conversely, supportive mentorship, academic drive, positive feedback from peers, and support from female physician-mentors strengthened the resolve of female physicians seeking out leadership positions [50].

In comparing harassment and discrimination within residency training, it is also important to recognize the heterogeneity among residency programs. Compared to female physicians and residents working in primary care, female residents and physicians in traditionally male-dominated fields, including surgery, encounter a disproportionate amount of sexist remarks or behaviors,

unwanted sexual advances, subtle bribery for sexual acts, and threatened sexual behavior from colleagues [51, 52]. Furthermore, medical student and resident reporting of harassment and discrimination increases with years of clinical experience. In comparing surgical and non-surgical residents, the likelihood of experiencing acclimatization to a patriarchal culture and, in turn, perpetuating abusive or discriminatory behavior increases with years of medical experience [52]. In such cultures, over time, female residents were also more likely to engage in psychological abuse, disrespect, and gender discrimination, which were more prevalent than overt sexual or physical abuse [52]. Interestingly, when female surgical residents and practicing surgeons transitioned into non-surgical residencies, teaching appointments, and/or primary care, reporting of harassment and discrimination reduced, and the patronizing and sometimes abusive teaching methods stopped [52]. While the reasons for these changes are not well understood and likely multifactorial, one possibility is that primary care settings are more supportive of female physicians because the number of female primary care practitioners is higher; these environments also foster collaboration, and primary care settings generally place less of a value on hierarchy, authority, and antiquated hegemonic structures than other procedural or surgical residencies [51].

While researchers and advocates work to better understand modern-day rates of harassment and discrimination, these studies are inherently biased by the perceived and real consequences of "whistleblowing." As previously stated, even in the #MeToo era, reporting sexual harassment remains stressful and risky; women who report sexual harassment can experience retaliation and marginalization, potentially leading to chronic stress and burnout [38]. It appears that strong female mentorship benefits women (and men, too) and can lead to increased opportunities for female leadership, which propagates stronger female physician support networks for the next generation. This suggests that a better way forward for the female physicians of tomorrow will be supported by the female physicians who continue advocating tirelessly today. Of note, the word "mentorship" can denote a formal relationship. Yet, women do not need to rely on formal mentorship

programs to benefit from the guidance of peers. Remember that a *mentor* is someone who believes in you!

Furthermore, in many workplaces women still earn less than men for equivalent work; significant sex differences in salary still exist among academic physicians even when controlled for age and years of experience, medical specialty, academic rank, and measures of productivity and human capital [53, 54]. A call to action for academic institutions and society in general to continue efforts to address the gender pay gap is greatly needed. Whereas there is the need to attract and retain the most talented medical workforce, closing the gender pay gap makes good economic sense.

The LGBT2Q Physician Experience

A discussion about gender, harassment, and discrimination in medicine would not be complete without acknowledging and exploring the experiences of physicians who identify as lesbian, gay, bisexual, transgendered, two-spirited, queer, and questioning (LGBT2Q). Physicians within the LGBT2Q community often take on important roles in advocating for LGBT2Q healthcare issues, including safety and equality in the healthcare system for patients and providers. Through their own personal and professional experiences, distinct and ongoing challenges are highlighted in relation to harassment, abuse, and discrimination.

Research exploring such experiences of physicians within the LGBT2Q community are sparse, and of the scant literature attending to LGBT2Q health, studies are often limited to the patient or consumer experience only. Healthcare institutions continue to uphold systemic barriers and discriminatory policies, as exemplified by the mandated cultural safety training largely ignoring diversity as it pertains to sexuality and gender identification [55]. Furthermore, though medical student-led advocacy groups call on faculties to teach LGBT2Q content, medical curricula often ignore transgender population health completely [56, 57].

Disclosure of gender and sexual identity continues to be an important stressor for medical and residency applicants in Canada.

In one study by Oriel and colleagues, 70% of gay and lesbian medical students stated their specialty choice had been influenced by perceived acceptance of their sexual orientation in that field [58]. A more recent study found that both medical students and residents within the LGBT2Q community were more likely to purposefully *not* disclose their gender or sexual orientation for fear of discrimination during the application cycle [59].

Practicing physicians within the LGBT2Q community can experience discrimination throughout the course of their work. In one study of LGBT2Q internists in Canada, 30% of respondents had been subjected to homophobic remarks on at least three separate occasions [48]. Furthermore, Brogan and colleagues found that almost half (41%) of lesbian physicians surveyed had experienced workplace harassment and were at a greater risk for developing depression compared to their heterosexual female colleagues [60]. Some LGBT2Q physicians even report choosing to "pass" as heterosexual in an effort to maintain the patient-physician therapeutic relationship and avoid potential problems with their patients [61]. Indeed, almost one-third of Americans randomly surveyed stated they would switch healthcare providers if their doctor identified as LGBT2Q, with a similar number of respondents stating they would switch clinics completely if LGBT2Q physicians were employed [62]. Such homophobic and discriminatory fears and attitudes persist with concerning negative impact on the health and well-being of individual physicians, patients, and society.

Discrimination against medical students, residents, and physicians identifying as LGBT2Q by patients, community members, peers, colleagues, and the system is completely inappropriate and unacceptable. In returning to the theme of allyship, it is important that one's words and actions foster inclusion and mutual-respect for all patients and colleagues, regardless of sexual and gender-identity. Silence surrounding LGBT2Q experience can be interpreted as a form of collusion, a disavowal of sexual difference. However, this silence must be broken in order to deconstruct this need to suppress difference, which can be indicative of a larger paradigm of gender relations. Digital social networks have an endless potential to educate about gender gap

through various initiatives including consistently addressing gender-related bullying and promoting inclusivity on their social channels, among others.

Working as a Physician with a Disability: "Do Not Disclose"

To many in the medical profession, the word "disability", may be equated with vulnerability. There may be a fear of negative professional consequences as a result of having a disability, such as fewer employment opportunities or options for professional advancement [63]. Beyond this, there may be a fear of being stigmatized, with others making assumptions about one's ability to practice safely. The fear of such consequences may lead to the practice of: "do not disclose." This lack of disclosure can lead to a sense of isolation, a sense of being "different," and an overall decreased sense of physical and psychological well-being.

Data supports that physicians are less likely to self-disclose a disability in comparison to the general population [64, 65]. As a result, there is limited up-to-date information on the exact number of medical trainees and physicians in Canada and the USA practicing with a disability. Available studies from the USA and Britain have found the most common disabilities among medical trainees to be attention deficit/hyperactivity disorder, learning disabilities, and psychological disabilities [63, 66]. The Ontario Medical Association also cites mental health as the number one reason for which physicians are on disability at any one time [67]. Learning disabilities and psychological disabilities have been described as the "invisible" disabilities, those that are not visible to the eye [68]. If individuals choose not to disclose their disability out of fear of negative consequences, then they may be unable to access appropriate accommodations or treatment to optimize and maintain their success and wellness. This risks the adoption of a survival mentality: "it will get better if I just get over this next hurdle" [63]. Unfortunately, in medical practice, there may be an endless number of hurdles to surmount and wellness may continue to deteriorate unless it is made a priority.

Fortunately, medical trainees and practicing physicians with a disability can be supported in their work with disclosure and proactive planning. A recent report from the American Medical Association highlights the importance of including disability support services in any statements welcoming applicants to medical school, along with communicating clear instructions for requesting accommodations [68]. The Canadian Association of Physicians with Disabilities was created to provide a national forum of discussion for physicians with disabilities. The understanding that "disability" does not mean the absence of ability needs to be promoted and accepted within medical culture, for the benefit of patients, providers, and society as a whole [65, 69]. There are a number of inspiring physician stories detailing how one can fight stigma and conquer environmental challenges in order to successfully practice as a physician [64–66]. These stories also highlight the need for institutional and systems-level support in combating stigma associated with physician disability.

Physicians are not superhuman; despite high expectations from self and others, physicians are human and therefore imperfect. Each physician has his or her own unique combination of skills and aptitudes, and the presence of a disability, be it physical, cognitive, or psychological in nature, does not change this. Physicians with disabilities may also be uniquely positioned to be able to advocate and improve accessibility and medical care for patients and others with disabilities [65]. For this reason, it has been argued that the makeup of the physician population should closely mirror the diversity of the patient population being served [65, 69]. As highlighted in this chapter, this principle should extend to all aspects of human diversity including race, culture, religion, gender, sexuality, and the presence of disability.

Socialization in Medicine: Practice as You Preach

From birth to the end of life, there are countless means through which one learns. In medicine, physicians are influenced by their supervisors, colleagues, patients, and the media. These

interactions, along with those experiences that precede medical training, combine to shape one's approach to caring for patients. This phenomenon is referred to as "socialization" and is defined as how individuals evolve to understand the attitudes and values encompassing a role [70]. Many practicing physicians are able to name a supervisor or mentor who helped to shape their professional identity. For this reason, it is important for physicians to recognize how powerful one's influence can be on a learner's attitudes and behaviors. If a physician mentor fails to appropriately address a witnessed act of discrimination (or is propagating an act of discrimination themselves), he or she is sending a message of intolerance to the learner. If medical trainees are to develop an attitude of inclusiveness and learn how to effectively address discrimination in the workplace, modeling of such attitudes and behaviors by those from whom they learn are key. Moreover, having mentors who reflect the diversity of learners and patients themselves (e.g., based on gender, age, sexuality, disability, race, or culture) is an important factor in fostering a sense of inclusivity.

Online Reviews, Cyber-harassment, and Physician Stress

Online scrutiny can be stressful for physicians. In recent years, physician-rating websites have become a means by which patients can publicly reflect on their level of satisfaction with care from individual physicians. These websites are often free to use and open forum, affording little or no control to the physician over what is being posted. While a 2018 study showed that the majority of ratings being posted are generally positive, there may also be comments that provide partial, misleading, or false information [71]. Webster has reported that studies of online ratings for physicians are flawed; they appeared to be based on a patient's general experience, reflecting physician friendliness and overall atmosphere, but failing to provide objective measures of quality of care [72]. The Canadian Medical Protective Association (CMPA) suggests

that physicians may be able to take "limited actions to correct or remove objectionable user reviews" but warns against responding publicly to online comments in the event that patient confidentiality is breached [73]. Some physician-rating websites may offer to remove a small number of negative ratings for a monthly fee, but the comments will reappear once payment ceases [74]. This has been described as being "akin to cyberbullying" [74].

Cyber-harassment, or cyberbullying, is a growing phenomenon worldwide and medical field and higher-education settings are no exception. It can manifest in many forms, from private messages sent via e-mail, text, and social media accounts to public campaigns and online platforms [75]. Trainees, faculty members, and staff at all levels can become targets of cyberbullying by anonymous or known individuals or organized groups [75]. Abusive and inaccurate posts can spread rapidly and widely on the Internet, potentially leading to real-life career consequences for targeted physicians. Although social media sites have been criticized as being too slow to respond (if at all) to cyberbullying, they are strongly encouraged to promptly address bullying and harassment on their platforms [75]. Many universities lack official policies on how to deal with cyber-harassment. A study examining 465 policies from 74 Canadian universities found that most institutions had policies around student conduct, discrimination, and harassment, but not all were specific to include online sites and digital media. It is suggested that university policies and procedures undergo frequent review and revision to remain current with the information and communication technologies that permeate the daily lives of university trainees and educators [76]. At an individual level, possible ways to manage harassment on social media include blocking "trolls," taking a break from social media, or leaving certain social media platforms altogether. In general, the community is supportive, and it helps to develop and know your online allies!

Skill-Building Exercise: Wellness in the Age of Online Reviews and Social Media

There is little information on how physician-rating websites impact physician wellness. What is known is that many physicians feel uncertain about how to deal with distressing posts on these websites [77]. While the ratings can aid in understanding what patients value in their physicians, it has been described that abuse occurs more commonly on these physician-rating websites in the forms of physician defamation and misinformation for patients [39].

Reflection questions:

1. Have you ever checked a physician-rating website to assess patient comments on the care you have provided? If so, what thoughts or emotions did this bring up? Did this information change your practice?
2. Conversely, have you ever used a physician-rating website to review information about your own or prospective physician(s), or to contribute information about other physicians?
3. In your practice, are there helpful ways in which you plan to gather information on patient satisfaction, feedback, and ideas to optimize patient care experiences?
4. Do you believe that physicians have a duty to dispute and challenge inappropriate or inaccurate health information posted online?
5. Do you believe that it is appropriate for physicians to look up publicly available online information about a patient in an emergency situation such as, for example, searching on Facebook for information following a patient's suicide attempt?
6. Do you believe that it is appropriate for physicians to look up publicly available online information such as Internet forum posts about a patient as part of regular clinical practice?

Check your Learning

Case Study: "You Are Not Alone"

Genevieve is a third-year resident in emergency medicine. She is working overnight in the busy emergency department and has just been asked by nursing staff to see a patient urgently due to complaints of worsening shortness of breath. The triage note indicates that the elderly patient has a history of severe COPD. As asked, Genevieve goes in to assess the patient urgently. When she introduces herself to the patient, she is met with a disparaging comment about "girl doctors". Attempts at explaining her qualifications fall on deaf ears and she is dismissed in order to go find "the real doctor." Dismayed, Genevieve seeks out her supervisor to solicit feedback on how to best approach the situation. Her supervisor tonight is known to be a strong clinician educator and well respected by program faculty and learners. After learning of Genevieve's experience in the clinical encounter, the supervisor accompanies her to meet the patient. Upon entering the room, the patient graciously greets the male physician. The supervisor proceeds to take the patient history and explain the next steps in care, before moving on to his next patient. The patient's refusal to be assessed by a female resident physician is not addressed.

Question. **Considering the above experience, how could Genevieve's supervisor have responded to address the gender-based microaggression?**

A. **State to the patient that discrimination based on gender is not acceptable**
B. **Transfer care of the patient to another emergency physician**
C. **Explain that Genevieve is a learner under his own direction so he will be the primary physician directing the patient's care**
D. **Explain Genevieve's qualifications, his trust in her abilities, and how she will be taking the lead in the patient's care under his supervision**

Answer: D ✓

Discrimination based on gender is unacceptable in any situation. This case study highlights the sense of powerlessness and abandonment a trainee may experience when put into such a challenging interaction. The importance of a supportive supervisor in this situation cannot be overstated. The importance of faculty training to effectively address instances of discrimination is emphasized, alongside the importance of clear reporting guidelines.

In summary, this chapter has explored how experiences of discrimination based on race, age, gender, sexuality, and disability may negatively impact physician wellness. Discriminatory attitudes and behaviors reflect opinions formed on irrelevant or external characteristics rather than merit. Open dialogue is critical to combat discriminatory attitudes, and discrimination should be a prioritized topic in medical education and practice in order to defend against threats to physician, patient, and societal wellness. It is the responsibility of all physicians to advocate for diversity and equality, and to stand up against harassment and discrimination of patients, learners, colleagues, and themselves.

Key Takeaways

- The cumulative effects of discriminatory attitudes and behaviors experienced by physicians can contribute to psychological distress and burnout [3, 13].
- Indigenous physicians are disproportionately underrepresented in medicine, although policy changes at local, provincial, and national levels are aimed to better support our Indigenous practitioners of tomorrow [50, 51]. Physicians are called to be advocates for Indigenous colleagues by calling out racism, supporting growth and inclusion of Indigenous learners, recognizing and valuing Indigenous expertise, and through reflection and unlearning practices aimed at creating space for Indigenous ways of knowing.
- Women, and especially women of color, are much more likely to experience gender-based workplace harassment and violence than their male and white colleagues.

While institutional policies aim to prevent gender-based harassment and discrimination, female physicians also cite supportive mentorship, strong female physician support networks, and policies supportive of work-life balance as important factors in career advancement [50]. A gender pay gap exists in medicine and must be rectified.

- Current cultural safety training programs often overlook LGBT2Q education as it pertains to physicians, patients, and other consumers of healthcare [25]. LGBT2Q physicians are more likely to be involved in local advocacy efforts on behalf of their patients, and it is equally important to foster inclusion, support, and allyship for physician colleagues who identify as LGBT2Q [56, 57].
- If medical trainees are to embrace and promote diversity and inclusiveness in medical communities and culture, as well as learn how to effectively address harassment and discrimination in the workplace, modeling of such attitudes and behaviors by supervisors, faculty, programs, and institutions is key.

Selected Resources

For further reading and additional resources regarding the impact of harassment and discrimination on physician wellness, please see Table 5.2.

Table 5.2 Selected resources about harassment and discrimination in medical institutions

Recommended resources	Description
Muzumdar A. Canadian Association of Physicians with Disabilities. https://www.capd.ca/?page_id=42. Accessed December 22, 2019.	The Canadian Association of Physicians with Disabilities website offers information and resources for healthcare providers practicing with a disability
RESPITE. Gender specific considerations in medicine. https://respite.machealth.ca/Integrate_5.html	This website further explores gender-specific considerations for physicians
The aging physician: Maintaining competence and practising safely. CMPA. https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2016/the-aging-physician-maintaining-competence-and-practising-safely	The CMPA offers information on maintaining competence and safe practice standards for the aging physician
Rainbow Health Ontario:https://www.rainbowhealthontario.ca	Rainbow Health Ontario provides the latest news, resources, and training modules for healthcare providers. Physicians can also list themselves as LGBT2Q-positive service providers through the website's directory
https://www.cmpa-acpm.ca/en/advice-publications/browse-articles/2014/when-medicine-and-culture-intersect	The CMPA offer an outline of cultural competency, cultural safety, and minimizing risk in the healthcare setting and in-patient interactions
Society of Physicians with Disabilities. https://www.physicianswithdisabilities.org/	This is a group within the Society of Healthcare Professionals with Disabilities; an online supportive community to provide disability-related resources and tools that are relevant for medical professionals, trainees, family members, and friends

(continued)

Table 5.2 (continued)

Recommended resources	Description
Is it Harassment? A Tool to Guide Employees. Government of Canada. https://www.canada.ca/en/government/publicservice/wellness-inclusion-diversity-public-service/harassment-conflict-resolution/harassment-tool-employees.html	This is a guide that helps in the analysis of a situation one believes might be workplace harassment; it can be used as a starting point to help understand what constitutes harassment. If one is still unsure if the situation constitutes harassment, the person should consult their manager, a departmental harassment prevention advisor, a departmental informal conflict resolution practitioner, the Employee Assistance Program, or a union representative
US Equal Employment Opportunity Commission https://www.eeoc.gov/eeoc/	This Commission is responsible for enforcing US federal laws that make it illegal to discriminate against an employee/job applicant based on race, color, religion, gender identity, sexual orientation, national origin, age, disability, and others

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