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FEATURE: EDUCATIONAL CASE REPORT

ERASE: a New Framework for Faculty to Manage Patient Mistreatment of Trainees

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Mistreatment by Patients: an Increasingly Recognized Problem

In medical education, mistreatment is defined as behavior, intentional or unintentional, which "shows disrespect for the dignity of others and unreasonably interferes with the learning process." [1] Medical educators and the Association of American Medical Colleges have long collected and monitored reports of mistreatment of medical students [2]. The literature is rife with studies on the prevalence and impact of bullying and harassment by supervisors in medicine [3]. Of growing concern, however, is mistreatment by those whom physicians are trained to serve: their patients [4]. Stories of discriminatory comments by patients toward physicians and other medical personnel abound and may be becoming more widespread in the current sociopolitical climate [5].

A large, recent survey found that nearly 60% of responding physicians had experienced biased comments from patients [6]. Physicians reported being subject to discriminatory language regarding race, gender, religion, accent, age, and weight, among others. Women and ethnic minorities were the most likely to report experiencing verbal mistreatment. Nearly 50% of physicians had patients request a different clinician based on a personal characteristic; gender, ethnicity, and race were the most common characteristics prompting such demands. Among physicians, over half reported a moderate to strong emotional impact of bias and discrimination [6].

Less is known about the prevalence of harassment, mistreatment, and discriminatory comments by patients toward trainees. A 2011 study of family medicine residents at one program reported that 45% of residents experienced intimidation, harassment, and/or discrimination; among those, 35% reported patients as a source [7]. A survey of psychiatry residents' experiences with patient mistreatment at 13 US programs revealed that 86% had been threatened, 57% had received unwanted advances, and 11% had been sexually harassed [8]. A 12-year longitudinal study found that among medical students, 60% reported experiences of harassment and mistreatment, with patients perpetrating 15% of incidents of sexual harassment and 11% of ethnicity-based mistreatment [9]. The impact of mistreatment by patients on trainees varies widely, ranging from no effect to avoidance of certain patient types, increased anxiety, or even change in career interest [8]. Trainees who experience mistreatment by patients at our institution—Yale University School of Medicine—have described that, in the immediate wake of such an event, their learning often stops. Equally concerning, faculty response in these situations is frequently felt to be insufficient or absent [4].

Educators are often at a loss regarding how to best help trainees who experience harassment and mistreatment by patients [4]. The academic medicine literature offers limited guidance other than emphasizing the need for greater faculty development in this area [10]. In this report, we describe the content, implementation, and evaluation of a novel approach to empowering faculty to address mistreatment of trainees by patients.

ERASE Framework

We developed a step-wise, standardized approach to empower physician-educators to recognize and respond to trainee mistreatment by patients. This framework consists of five strategies, aptly captured by the acronym ERASE: supervising physicians should *expect* that mistreatment will happen, *recognize* when mistreatment occurs, *address* the situation in real time, *support* the trainee after the event, and *establish* a positive culture. At each step, we sought to understand and overcome

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any barriers that prevented a physician from responding appropriately.

Expecting that mistreatment will happen allows faculty members to prepare for future episodes, which often occur without warning. Faculty members should become attuned to the multiple ways in which mistreatment may present and work to develop intervention strategies. Being prepared with specific language/techniques increases the likelihood that a supervising physician will address mistreatment in the moment. In order to promote a positive learning environment, faculty should explicitly outline the ways in which they are available to support trainees even before a mistreatment event occurs. A proactive approach reinforces a culture of mutual respect between physicians and patients which in turn helps to ensure a safe space for trainees to report any concerns about patient interactions.

Recognizing mistreatment is an important, but often challenging, skill. Some instances of mistreatment are obvious (e.g., a patient using a racial slur), while other instances may be more subtle (e.g., a patient ignoring a trainee of color). Given the frequency with which mistreatment by patients occurs, some physicians may be desensitized to the experience. When the mistreatment targets a member of the treatment team representing a different demographic than the supervising physician, he/she may be less likely to recognize the episode as troublesome, even if a learner is negatively affected. This may be particularly true with less overt forms of mistreatment such as microaggressions or seemingly "complimentary" language by patients that learners experience as offensive or otherwise problematic (see Table 1 for examples). Paying attention to trainees' nonverbal cues such as changes in body language, affect, or interpersonal dynamics can be helpful. Supervising physicians should be open to the idea that trainees' experience may differ from their own.

Addressing mistreatment in real-time requires consideration of the clinical context, the goal of the intervention, and the tone best suited for the response [11]. Responding in the moment can serve a variety of purposes, including halting the problematic behavior. A calm, professional response, or "interruption," demonstrates to the trainee and the rest of the treatment team that the mistreatment has been acknowledged and will not be tolerated. Physicians may be concerned that confronting patients is too time-consuming, but many of the interventions take just seconds. Others may feel that absorbing mistreatment by patients is part of being a clinician, believe that "the patient is always right," or may fear that negative interactions with patients may result in lower patient satisfaction scores. Some may worry that confronting or redirecting a patient may further inflame a situation (and at times this can certainly be true). However, conversations with patients can be firm, corrective, and respectful at the same time. Having prescribed, specific language to use in different situations can be helpful to physicians (see Table 1). Even if a decision is made not to address the situation directly with the patient, supervising physicians would be remiss not to acknowledge the mistreatment with their team after the encounter.

Supporting the trainee is a vital step that can take many forms. Supervising physicians should recognize that learners may have different reactions to similar stimuli and will need varying degrees of support. One adaptable technique is for the faculty member to acknowledge that a potentially challenging interaction has occurred, share his/her personal reaction as an opening to ask a trainee or the team how they experienced it (e.g., "I found that patient interaction to be pretty tough. How was it for you?"). Team debriefing conveys a sense of openness to hearing concerns and reminds trainees that mistreatment is not to be tolerated and can empower trainees to respond similarly when facing mistreatment without an

Table 1 Sample scenarios and interventions for trainee harassment or mistreatment by patients

Problem	Example	Intervention	Sample language
Overt derogatory language	Patient uses racial slur in reference to a student participating in her care Angry patient yells misogynistic term at female resident	Set clear limits	"This clinic/unit/department is an area where we treat each other with mutual respect. We cannot tolerate that kind of language." "Mr. X, we do not use that kind of language here. We are only trying to help you, which is harder to do when you talk like that."
Microaggressions	Patient addresses female trainee as nurse Family member asks Latinx trainee to serve as interpreter	Education/explanation	"As she explained, Dr. Z is the resident physician who is caring for you. Nurses in this hospital wear blue scrubs and will introduce themselves as your nurse." "Ms. X, this is not the interpreter; this is J., one of the medical students on our team. Have you met?"
"Complimentary" comments	Patient comments on student's attractive appearance Patient associates resident's ethnicity with superior intelligence	Redirection/reframing	"I know you mean well, but we are more concerned about our students' skills and abilities than their looks." "Ms. X, Dr. Z is an intelligent physician, but that has nothing to do with his ethnicity."

attending present. In certain circumstances, a senior team member may prefer to follow up with a trainee privately. In planning next steps (e.g., whether a trainee should continue in the care of the patient versus transfer care), collaborative decision-making with the trainee respects his/her authority [10].

Establishing a positive culture requires interventions beyond the clinical encounter, usually involving the leadership of the educational program or healthcare institution. Because of their relative power in the institution, clinical attendings who witness patient mistreatment of trainees may be in the best position to influence administrative parties. Scholars have suggested that program leaders should educate trainees about the possibility of mistreatment by patients, express openness to hearing trainee concerns, and identify point people at various training sites who are available for support [10]. Institutional reporting mechanisms should be developed, revised and disseminated on a regular basis to remind faculty and trainees that they are not alone in managing these conflicts. Academic institutions and national organizations should collect data on the frequency and impact of trainee mistreatment by patients [4]. Healthcare institutions should consider patient- and staff-targeted education including signage to publicly reinforce values like mutual respect in the clinical encounter.

Teaching ERASE

We developed an interactive training session for faculty and residents to learn and practice using the ERASE framework. The authors delivered four, 1–1.5 h workshops in late 2017/early 2018 at various departmental meetings around the academic medical center: (1) clerkship educator development session (attended by 25 faculty and residents in psychiatry, internal medicine, and pediatrics), (2) on-site veterans' affairs primary care center (11 faculty in internal medicine), (3) psychiatric hospital (16 psychiatry faculty), and (4) mental health center (17 psychiatry faculty and residents). Sessions ranged in size from 11 to 25 participants for a total of 69 participants.

The sessions began with a description of the problem of trainee mistreatment by patients including prevalence, impact, and personal narratives (15–20 min). Participants engaged in a guided discussion of their own experiences with mistreatment of trainees including the challenges of managing such events (5–15 min). Session leaders encouraged participants to compare and contrast trainee mistreatment by patients with trainee mistreatment by members of the health care team. At each session, participants identified similar barriers to intervening in instances of mistreatment by patients: feeling like they did not have time, fearing alienating the patient/low patient satisfaction scores, and not knowing what to say in an uncomfortable situation. Frequently, participants described a lack of awareness and/or existence of a formal system for reporting or addressing mistreatment by patients, unlike established mechanisms for reporting mistreatment by another member of the healthcare team. Session leaders then introduced, in lecture format, the ERASE framework and how it might be applied in various types of mistreatment (15–20 min; see Table 1). Participants were then divided into small groups (4–6 people) and worked together to apply the ERASE model to a specific case (10–15 min). Each small group then reported back to the larger group about their case, its challenges, and how the ERASE framework could apply, including what specific actions and language they might use (15–20 min).

We evaluated the training by having all participants complete a Likert-scale questionnaire regarding their own skills and attitudes around trainee mistreatment immediately before and after each session. The study was granted exempt status by Yale's institutional review board. Nearly 80% of participants had not previously received specific training on recognizing and addressing episodes of trainee mistreatment. After the session, participants expressed significantly more confidence that they could recognize different forms of mistreatment and employ a standardized approach to addressing incidents of mistreatment. Though these initial results are encouraging, it is not clear how generalizable the findings are. The sample size was small (69 voluntary, non-random participants over 4 sessions conducted by the 3 authors) and included members of just three clinical departments at a single academic medical center. The pre-post design did not include a control group. Furthermore, we measured only participants' attitudes and self-efficacy immediately after the session and do not know whether participants applied ERASE in actual episodes of mistreatment in the clinical setting.

Discussion and Next Steps

Mistreatment by patients is an unfortunately common experience in clinical medicine with potential for significant psychological impact on physicians and trainees. However, most physicians have not been trained in how to address episodes of trainee mistreatment by patients. The ERASE model is a novel approach for training physicians to appreciate the negative impact of mistreatment and to address it in order to support an optimal learning environment for trainees.

While the ERASE trainings seem to be preliminarily effective among primary care and psychiatry faculty and residents, future work should include dissemination and evaluation of the training session among faculty of other disciplines and at other institutions. Several clinical departments at our medical school have invited us to deliver trainings to their physicians. Furthermore, nursing leadership at our affiliated hospital has recognized patient mistreatment of staff as a significant

problem and has asked us to help develop analogous training for nursing staff. Given the anticipated need faculty development across all disciplines and limited availability of resources, we have begun to develop a "train-the-trainer" model to adapt the model for interdisciplinary use and to disseminate this model more broadly. We view these efforts as an excellent example of the final "E" component of ERASE—establishing a positive culture.

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Compliance with Ethical Standards

Ethical Approval Exemption granted by the Yale University Institutional Review Board.

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