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Journal of Medical Education and Training

Research Article | Open Access

Patient Prejudice towards Providers (PPTP): The Resident Physician Experience

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Received: 23 December 2021; **Accepted:** 07 February 2022; **Published:** 11 February 2022

Abstract

Background: Patient Prejudice Towards Providers (PPTP) is bias towards physicians, nurses and other health professionals based on race, gender, religion, and country-of-origin. PPTP is especially harmful to medical trainees who face moral dilemmas and vulnerability over how to respond to it.

Objective: This study, completed in 2020, aimed to explore the experience of PPTP among resident physicians.

Methods: Using notifications to residency training programs and word-of-mouth, eleven one-on-one interviews were conducted. Of these, 57% were female and self-identified minority status including: Indian American (18%), Middle Eastern (9%), East Indian (9%), South Asian (9%), Latinx (18%), mixed race (9%), African American (18%), African (9%) Analysis of the transcribed interviews was conducted independently by the research team using an iterative process within and across narratives; findings were merged to identify themes relevant to the research objective.

Results: PPTP behaviors reported by resident physicians ranged on a continuum of offense, from negative comments and behaviors to refusal of care. There was a lack of support and even passive participation in the PPTP by colleagues, which led to decreased job satisfaction and motivation, as well as impaired patient rapport. PPTP decreased system efficiency, compromised care, and lowered morale/communication within the team.

Conclusions: Residents report ongoing experience with PPTP and poor system support for victims to the detriment of resident wellbeing and patient rapport. Residency is an optimal time for education regarding PPTP and development of programming to to provide support and response to this damaging dynamic.

Keywords: Patient bias; Prejudice; Provider mistreatment

Introduction

Inequities in healthcare due to implicit bias are well documented [1], but the reverse situation, i.e. the adverse outcomes of Patient Prejudice Towards Providers (PPTP) has received little attention from social justice researchers [2]. PPTP is especially damaging during residency when vulnerable learners from minoritized groups can be targeted by patients while lacking agency to respond due to their trainee status . To date, the majority of scholarship on this topic is anecdotal despite the importance of recruiting and retaining diverse trainees [3]. To our knowledge this is the first study investigating patient/family prejudice directed toward minoritized residents and fellows. Documentation of this toxic dynamic will help raise awareness and inform mitigation strategies.

Review of Literature

While the workforce in healthcare is slowly diversifying, Black, Hispanic, and Native Americans comprise only 9% of practicing physicians [4]. Minority physicians have reported discriminatory behaviors during training when they experience lower expectations from supervisors and also stricter consequences for mistakes. This might contribute to the perceived social isolation of minority physicians during medical training [1,4]. Osseo-Asare et. al., suggest that the discrimination minority physicians experience during training may contribute to burnout and limit their educational opportunities [4].

The educational years prior to earning status as an attending physician are challenging, especially for those from minoritized groups. Studies have found that 95% of all medical students experience at least one form of harassment or discrimination which contributes to hostile, stressful, and uncomfortable learning environments and impaired student performance [5-8]. Sheehan and colleagues found that medical students who frequently experienced harassment were less likely to complete assignments or provide optimal patient care, and were found to have more emotional health problems, such as depression and anxiety, when compared to their non-harassed counterparts [5]. This is significantly pronounced in minority trainees [9-11].

Residency is a critical time during which trainees develop their personal and professional identities and complete the final phases of their education [4]. Minority residents are 30% more likely to withdraw from residency than their white counterparts, and 8 times more likely to take extended leaves of absence [4]. Since minoritized patients have better outcomes when cared for by minoritized physicians, higher drop-out rates of minority trainees during residency have negative implications for patient care [12].

The source of bias and prejudice toward resident physician trainees can be inherent to the healthcare system but also a consequence of patients and families, who are struggling to survive in an increasingly complex care environment [13]. In particular, minority providers can be the victims of frustration experienced by patients and those who accompany them.

There is a growing body of anecdotal reports by those in the health care professions describing rejection and prejudice from patients due to a clinician's race, gender, ethnicity, or religious affiliation. In addition to covert forms of bias such as microaggressions, patients can overtly decline to receive care which might be reasonable in some circumstances, (for example language barriers or gender preferences due to religious reasons or prior abuse), but cannot be justified or supported if it stems from a discrimination [14].

From an ethical perspective, prejudiced interactions from patients toward the medical professionals who provide their care can create a moral conflict since there is a duty to treat. At the same time, there is a legal obligation not to treat patients against their expressed wishes [14]. This dilemma has not been systematically studied or addressed despite the frequency of occurrence. In instances where patients discriminate against physicians there is little guidance from hospitals and training programs to effectively balance the patients' interests, the physician's rights, and the duty to treat [14]. Historically, the burden to find solutions to these situations has been on the affected health care professional.

In their landmark publication, Paul-Emile et al. emphasize the integral role organizational leadership should play in addressing these challenges [14]. Institutions are responsible for balancing the moral and legal rights of both patients and employees, especially trainees. Healthcare workers have the right to a workplace free of discrimination (Title VII of the 1964 Civil Rights Act) and patients have the right to effective and compassionate care along with the right to refuse care and treatment in general or by a certain physician. This situation becomes even more difficult to resolve in emergency situations [15].

Evaluations, both from supervisors and patients are an integral part of performance reviews during residency training. This could pose a challenge if these reviews are influenced by bias and prejudice [16]. Since poor evaluations may have negative implications for remuneration and future professional advancement, resident physicians can find themselves balancing evidence-based practice and moral obligations to "do no harm" with "catering to" explicit/perceived rejection by the patient. As stated by Kueakomoldej et. al., addressing these injustices is the responsibility of management or supervisors [16], but is too often compromised, with policies failing to remediate the root causes of PPTP. Too often, the employee's experience is minimized while the patient's egregious behavior, including requests for different staff, are legitimized [16].

While discrimination and prejudice from patients causes physical and emotional stress to physician trainees [4], there is little research on the professional impact of this dynamic or how residents attempt to cope, if any are made at coping. The purpose of this study was to examine the PPTP experiences of residents who self-identified as minorities to better understand this relational concept and to explore potential educational and health system interventions.

Methods

Methodology

Absent comprehensive and appropriate survey measures, qualitative methods provide a theoretically grounded approach to understand a concept [17]. Teherani et al. (2015) say: "Qualitative research focuses on the events that transpire and on outcomes of those events from the perspectives of those involved". This is the intent of this investigation [18].

As no empirical measure was available to examine PPTP, this study's protocol included an interview guide of 11 open ended questions and appropriate prompts derived from a literature review and professional discussions (see Appendix A). Content was validated by a panel of peer experts and used in 1:1 interviews with volunteer resident physicians at an academic medical center.

Invitations to participate were disseminated through official channels (announcement of the program during noon conferences or teaching sessions, email announcement from program directors or other faculty) and by word of mouth. Interested volunteers who self-identified as being of minority status due to race, ethnicity, or country of origin, were asked to contact the research assistant, who obtained written consent and established a time and place for the interview. Inclusion criteria to participate in this study were, ethnic or racial minority and/or country of origin other than the US.

The interviews were conducted by author NS, research assistant in the study. Coding and data extraction was performed by all three authors (CD has extensive experience in qualitative methods from prior work, DAA and NS received training on qualitative methodology and cognitive interview techniques).

Participants

In 2019/2020 a total of 17 residents volunteered to be interviewed. Six did not participate due to a lack of availability during the data collection phase. On average, interviews lasted one hour and occurred in person or virtually by the same research assistant; no observers were present during the interviews. Periodic audits of taped interviews to ensure fidelity were conducted by the primary investigators. No additional or follow up interviews were scheduled with the participants after completion of the initial interview. Transcripts were checked against the audio files for completeness and accuracy by the interviewers. The participants did not review complete transcripts.

There was no conflict of interest between interviewees and interviewers. The interviewees were not involved in other aspects of the study. The interviewers did not have direct supervising roles in the participants' education.

By the time of the eleventh interview, data saturation was reached, defined as "the point in data collection and analysis when new incoming data produces little or no new information to address the research question [19]". This sample size was within parameters suggesting that most themes to be discovered in a qualitative study occur within the first six interviews [20]. Given the homogeneity of our sample (all resident physicians at a similar age and stage of their careers), it was not unexpected that this occurred, and as stated by Guest et al. [19], "Using the ≤5% new information threshold, our findings indicate that typically 6–7 interviews will capture the majority of themes in a homogenous sample (6 interviews to reach 80% saturation)." No repeat interviews were conducted.

Analysis

The 11 completed, audio-taped interviews were manually transcribed from the audio-file into a word document, including pauses and emphasis. The transcripts were analyzed using inductive and deductive coding to extract categories and themes. Both the written transcripts and the audio-recordings were used to identify unintended influences for example from the interviewer. The three authors coded all transcripts individually to compare the extracted codes, discuss and resolve differences and define the themes and categories. After each researcher had completed their review, the team met to discuss individual findings and to identify themes that emerged from the preliminary reviews. The team came to consensus on four themes related to PPTP that were extracted from the interviews, which were consistent with published anecdotal reports but enhanced by this scholarly exploration.

A grounded theory approach was employed to identify the themes and categories. The extracted data is regarded as real; for analysis and interpretation the authors are aware that additional situational influences and the perspective of the interviewer affect findings. Extracting the verbatim answers of the interviewees the authors tried to understand the intended meaning of the statements by trying to minimize the influence of their own assumptions [21-23].

IRB

Permission to conduct this study was received by the Penn State University IRB, Study #_00011157.

Results

Demographics

Six interviewees were female (57%) and all self-identified as minorities based on race, which included Indian American (18%), Middle Eastern (9%), East Indian (9%), South Asian (9%), Latinx (18%), mixed race (European/Caribbean) (9%), African American (18%), African (9%) (as reported by participants). For additional demographics, see Table 1.

In analyzing the narratives, it became clear that all interviewees could describe difficult patient situations. In addition, there was also a ready understanding of the concept of PPTP and agreement that

Table 1: Demographics.

Category	N	Approx. %
Gender*		
Male	5	45
Female	6	55
Age	28.1 (M)	24-32 (Range)
Role		
Resident	11	100
PGY1	1	9
PGY2	4	36
PGY3	4	36
PGY4	2	18
Medicine	7	64
Medicine/surgery	1	9
Surgery	3	27
Pediatrics	4	36
Pediatrics/ Adult	6	55
Adult	1	1
Region of birth		
North America (US)	5	46
Africa	2	18
Europe	1	9
Asia	1	9
Middle America	1	9
Caribbean	1	9
Race/ Ethnicity*	2	18
Indian American Middle Eastern	1	9
East Indian	1	9
South Asian	1	9
Latinx	2	18
mixed race	1	9
African American African	2	18
	1	9
Citizenship		
US only	8	73
US and other	2	18
Other only	1	9
Medical School		
US	10	91
Other	1	9

*Self identified

this dynamic had been directed at them during their time as medical students and residents in various locations and rotations.

The defining of an experience as "PPTP" was influenced by two factors: frequency and co-occurring behaviors. When prompted about how often PPTP occurred, one resident said:

"Oh yeah at least once a week, like once or twice a week. This is just being a female physician because most people expect this male physician picture in their mind. You walk in and introduce yourself as a doctor and they'll like keep telling you, like, oh yeah you're the nurse right? No, I'm the doctor."

And, from another:

"Usually, when there are more frequent occurrences like that close together, then it starts to bug me, when it happens frequently. One-off occurrences don't really bother me, but when it's a lot of people saying it, it just sort of amplifies the magnitude"

As in the quote above, gender emerged as a potential influence on the incidence of PPTP. A male participant said, *"I imagine for a young female, particularly a minority doctor, it probably happens, I would guess, maybe even daily,"*

Another interviewee noted that:

"They question the authority there. Or they don't exhibit polite body language. Like for instance, they won't stop eating when I'm explaining something to them or pay attention or get off their phone. Versus, I see with the male providers the phones drop, voice drops, hands folded and they're paying attention."

Body language also shaped the interpretation of behavior as prejudiced rather than conversational. The tone of voice, sighing or eye rolling signaled disrespect or put their role as physician into question. One provider commented on his own accent and how it impacted patient dynamics:

"Even if no one said it as frankly…sometimes when you talk to someone you feel that they are not at ease. Usually, it's their facial expressions. They go from being at ease, smiling, to a little bit guarded. Even if they are smiling, it's not like a true smile."

Themes

Four themes related to PPTP emerged from the narratives, offering a richer understanding of this dynamic as well as how resident physicians attempted to address it. Exemplar statements supporting each theme and subtheme are provided in Table 2.

Theme One: A Continuum of Offense

The negative behaviors exhibited by biased or prejudiced patients were described on a continuum that ranged from subtle to explicit. A common characteristic of the reported microaggressions was their seeming harmlessness or innocence to observers; such hurtful comments could be easily repudiated by the person committing them [24].

While such comments illustrate the more covert forms of aggressions reported, observations of the resident's appearance, questions about their countries of origin, and probing about qualifications were frequent, leading to a perception that the interviewee was not as qualified or acceptable as a non-minority resident. More disturbing scenarios occurred when patients or their families were reluctant to engage in care or even suggested a preference for another provider.

Theme Two: Framing a Meaningful Response

While interviewees were all negatively impacted by the experiences of PPTP, their responses were often individualized. Most described trying to persevere with care while ignoring the patient's negative behavior, which caused ethical challenges.

When residents on the receiving end of PPTP sought input from others such as their supervisors, they described a lack of support. Similarly disturbing was the lack of support from colleagues, witnessing, but not intervening or offering support. The failed behavior of these bystanders was demoralizing in a different way to the interviewees, who perceived that their coworkers might believe that the criticisms being directed at them were true.

Theme Three: Impact on the Therapeutic Relationship and Team

There was a recognition from interviewees that while PPTP presented a moral struggle for individual residents, fallout from the behaviors impacted not only their relationship with the patient and their family members, but it led to disruptions of team function due to negative communications. Some interviewees admitted they felt less motivation to provide the best possible care for individuals who disrespected them, while others found it difficult to maintain team cohesion and productivity when PPTP occurred.

Theme Four: Accommodating PPTP Into Professional Identity

While interviewees as resident physicians perceived no alternatives

Table 2: Themes.

Theme	Subtheme	Exemplar
Continuum of Offense	Comments on appearance	"I walked into a patient room and they ask if I was the janitor. And I'm like, "What?" And the funniest thing is that same day the security guard, [as] I was looking for my ID, he made the same comment. He was, 'Oh I see you have the purple jacket; you must be one of those people that work downstairs.'"
	Questioning authenticity	*"…but even when I said I was from the state or whatever or that I had gone to the nearby university it wasn't enough and the secondary question of, "Oh well, where are you from from?" or "Where are you originally from?" or "Where are your parents from?"* *"People believe that training isn't as good as it would be in America."*
	Rejection	"When I walked into the room he was fine. When I started speaking he was like, 'Get out, bro. I need an American doctor." "… so I told him I have another colleague who is Lebanese, but if you want to get another colleague to do another assessment for you I can get them. He said, "No, I hate Indians as well."
Framing a Meaningful Response	Choosing to react individually	*"I used to get angry. I used to …and frustrated. I still do every once in a while. Now I'm just kind of tired of it. It gets exhausting …"* *"And I try and let them understand that, although they're coming at me in an aggressive way. I'm trying to understand where they're coming from. And then I lead, I segue into: Can you tell me more about why you don't want me be part of your care."*
	Relying on others as allies	*"Our supervisor told administration, 'Is this a real complaint? Is this a complaint that should be looked at?' And administration at XXX said, 'No of course not. It's just something that we had to tell you about because someone complained about it, but we're definitely not considering doing anything about it."* *"There was actually no debriefing. There was no mention of it. There was no handling. It was just kind of like…'well, that's a shame." That sucks…it wasn't much of a conversation."* *"I think it should be zero tolerance. I think what's logistically possible though is we should feel supported and empowered and comfortable to report it to our team, to people in leadership positions above us, who can make system-wide change or employ particular interventions with that patient."*
Impact on Therapeutic Relationships	Choosing to continue care	*"You have to keep reminding yourself, you have to give the patient your best. But, when the family has an attitude…you're not really as motivated."* *"So generally, I try to just steer the conversation back to a question about their care so I don't really have to answer [questions about that]. If that doesn't happen then I just kind of give 'em 30 seconds to a minute and then I just tell them, 'Let's focus back on what's going on here because, obviously, this is not relevant to your care right now.'"* *"… I don't show like any frustration or anything like this. I try to contain my emotions and let the situation pass."*
	Impact on productivity	*"So, I think if you have that lack of respect for each other, it's hard to get that adequate history and physical. And so, in that sense I think you would be delivering suboptimal care."*
Making Meaning of PPTP	Giving patients the benefit of the doubt	"You are pretty vulnerable when you are in a patient gown lying in a bed and you are going to have surgery with a room full of white coats around you." "And the problem with parents also is when your child is sick it just distresses the entire family structure, right?"

	Coping strategies	"To be frank, I usually just kind of snicker and then say, 'Alright. Great seeing you. See you next month.'" "'…where are you really from?' and I said, 'I am from XYZ.' And they're like, 'No, like what are you?' And I'm like, 'What do you mean what am I? I'm a human.' So, I try to answer the question to not give them what they want because people are shy of specifically asking what ethnicity you are. If you actually give them enough answers to where they have to confront what they're trying to figure out is what ethnicity you are, they tend to stop."

to continuing to provide care when PPTP occurred, they did struggle to understand the dynamic and find ways to cope with the behaviors as part of their practice. Their reactions, in general, did not involve organizational resources but focused on making meaning that would become part of their practice as a physician. Often, they felt as they progressed in their training, they became more adept at responding to patients who exhibited prejudice and bias.

The approaches they described using to understand and react to PPTP were consistent with those identified by Folkman and Lazarus (1980) in their research on coping through cognitive strategies [25]. The first option interviewees turned to was taking action to diminish the PPTP, either by continuing to act as if they had not been offended or upset by the patient's behavior. Sometimes, they responded as if a challenge to their competency had been issued and expended more energy providing exemplary care.

Another approach to involved reframing to respond to the scenario. One interviewee found it helpful to consider the emotional state of the patient, while another resident used humor to change the environment.

Interventions

In the interviews participants were asked to suggest potential interventions to address PPTP. The interviewees felt strongly that interventions need to come from the supervising physician and can take many forms.

Verbal interventions can be affirmative messages communicating to patients and coworkers that the resident is a valuable and qualified member of the treatment team or a direct dialogue with the patient requesting that they stop the negative verbal or physical behavior were suggested as options.

One resident remarked about the reaction of her attending physician to a biased patient:

"She essentially just told, […], without being shy about it, said that his remarks were not acceptable. And she was very clear about it. And she also made it very clear that we were a team, including the student, and that we would play a role in his care. And that we functioned as a team."

Interventions or support from co-workers was described as immensely helping and encouraging. One resident summarized:

"I think the most protective thing that I have is a group of friends in […] different specialties…"

Discussion

Resident physicians who are minoritized because of race, ethnicity, or country-of-origin are deeply impacted by PPTP. Motivation to provide the best care possible is difficult when the trainee is exposed to bias and prejudiced behavior from those they are treating. Relationships with other team members, especially those in a position to offer support, are negatively affected as well. Status as a trainee caused frustration and uncertainty when residents perceived that their supervisors might evaluate them negatively if they reported PPTP, or consider critical comments made by patients as valid.

While almost all residents interviewed reported situations of explicit rejection and hostility, microaggressions were experienced far more frequently. Since academic institutions face an important legal dilemma when addressing PPTP and , this is an important distinction. While microaggressions require nuanced interventions [4] and trainees have the right to a workplace free of discrimination and harassment [26], federal law also mandates that patients have a right to treatment in Emergency Situations [15]. When a resident physician is confronted with PPTP, they experience the tension of these competing laws, struggling to balance their duty to provide care with their right to be treated respectfully. As both students and employees, resident physicians may not have the ability to respond authentically due to fear of repercussions and negative evaluations.

Hospitals have historically complied with change of provider requests when they are based on racial preferences [14], since antidiscrimination policies and laws do not discourage complying with these requests [16]. However, hospitals have started to adopt policies, such the first of its kind: "2017 Penn State College of Medicine Patient Rights Policy Update", which states that requests for a change in provider "based on… race, ethnicity, religion, sexual orientation or gender identity will not be honored" [27].

A basic tenant of medical care learned on the first day of medical school is nonmaleficence. While medical ethics are often overlooked in residency programs, residents feel a deeply ingrained responsibility for the well-being of the patient, which complicates their response to such prejudiced behavior and impacts on their own wellbeing.

Effects of PPTP on Resident Physicians

It has been reported that individuals who are affected by discrimination, bias and prejudice experience significant rates of psychological and physical effects [28]. Increased rates of burnout, depression and anxiety have been reported as well as higher rates of elevated blood pressure and cardiac disease. As detailed above, the residents we interviewed described the psychological toll PPTP has taken on them already in their early career stages. Emotions ranged from self-doubt and avoidance to anger and decreased morale. These feelings and resulting actions can be expected to impact learning and professional development as well as organizational commitment and trust.

In our interviews, we repeatedly heard the tenet that "one has to rise above" situations of PPTP, suggesting that it represents a unique part of professional development for minority groups. Further, difficulty interacting with patients because of rejection might result in less detailed presentations to the supervising attending and make the affected resident appear subpar when compared to peers. As all trainees know and have experienced, patients tend to come forward with additional information when the supervising physician enters the room. In cases where patients deliberately refuse engagement with a minority physician, the supervising physician might get the impression of poor skills or work ethics of the resident. It is extremely important that faculty in residency programs become aware of this phenomenon to mitigate its effects [29]. Continued efforts to diversify the physician workforce remains an important goal and is often shaped by educational experiences [30].

Institutions in certain regions might face difficulty recruiting a diverse group of trainees or clinicians due to repeated patient bias [27]. Institutional leadership is critical to address an anti-discriminatory mission [3]. Increasingly, medical centers are being urged to adopt protocols and infrastructures to protect their providers from PPTP [31].

Interventions

Resident physicians, like all members of the health care team, deserve protection in hostile patient encounters and often cannot handle these situations entirely on their own. In the interviews many residents suggested possible interventions and approaches to these situations. While interventions from supervisors, peers and bystanders are described as very helpful and supportive a more systemic approach is needed. Helpful interventions require further research to differentiate whether residents feel comfortable and wish to address the situation themselves (as was affirmed by some but not all our participants) versus others who saw it as the role of others to be empowered to intervene. In either case, when these situations arise, the supervisor must assess the situation to determine preferences of the affected physician for support and ability to continue providing care.

It is also often difficult for other residents and trainees to know when/if to intervene in PPTP. Educational programs with simulated scenarios and prepared scripts can be helpful strategies [32]. The approach used with bystander training to decrease incidences of dating abuse among college students may be a model, drawing on two goals: (1) To increase the likelihood that negative situations are safely interrupted and (2) To create a community and atmosphere that discourages this aggressive and negative behavior [33]. By using these overarching objectives, non-affected physicians and other colleagues can follow principles of bystander engagement. As taught in the Step Up program of Columbia University the five steps of bystander intervention are: (1) Notice the event, (2) Interpret the situation as a problem, (3) Assume personal responsibility, (4) Know how to help, (5) Step up! [34] making a bystander plan beforehand can significantly lower the threshold to recognize discrimination and safely intervene [33,35].

Most importantly, unaffected peers should never use PPTP situations to their own benefit as our participants suggested happened on occasion. For example, taking over and presenting themselves as more proactive and knowledgeable in the clinical encounter and when precepting with the supervising physician should not be tolerated. A universal curriculum for all providers would allow for education on what constitutes discriminatory remarks and behaviors toward any team member [5], and for dissemination of solutions and bystander intervention protocols [5]. Institutions must have a zero-tolerance policy and protocols to report all types of discrimination, with the intention that all complaints be thoroughly examined by trained mediator [5].

In addition to robust zero-tolerance policies, academic institutions must create actionable strategies and infrastructure that supports both potential targets and bystanders are needed. Each employee needs to contribute to the reduction of PPTP-induced moral distress by acknowledging biases, promoting dialogues about cultural competency, and advocating for a just and equitable workplace.

Limitations

This study was preliminary and conducted in one location, although some experiences shared by interviewees were reported to have occurred at other institutions during earlier stages of training. The relatively small sample size is offset by the heterogeneity of minority resident demographics and degree of saturation reached.

Future Directions

When considering what it takes to educate and train those who will shape a nonracist health care workplace environment for both the givers and receivers of care, this research highlights the need for accurate and comprehensive recognition and assessment of the scope of the problem. Further research with other members of the health care team will be an important first step; efforts to construct a questionnaire to survey attending physicians and nurses, based on initial study data, have begun.

The current debate on racism and discrimination is prompting non-minority physicians to critically assess their privilege [36]. Awareness is growing that behaviors like PPTP do not only impact those from minority groups but affect all levels in the healthcare system and all persons involved as either a target or bystander. Research on interdisciplinary experiences of PPTP will prompt those with authority and expertise to develop a comprehensive, multi-level, culturally relevant strategy that informs interventions to target individuals, communities, and the nation as a whole [37].

Funding/Support

This project was funded through the Junior Faculty Development Program at Penn State 2018-2021, awarded to Dr. Andreae

Ethical Approval

Permission to conduct this study was received by the Penn State University IRB, Study #_00011157.

Previous Presentations

Junior Faculty Development Program Poster Presentation 02-2019. 2020 ASBH 22nd Annual Conference – Virtual, Paper Presentation Q&A 10-16-2020, 3-3:30 pm.

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Citation: Andreae DA, Sood N, Dellasega C. Patient Prejudice towards Providers (PPTP): The Resident Physician Experience. J Medic Educ Training 2022; 6:072.