2019

Mistreatment of Providers by Patients in Emergency Medicine

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Background

• Mistreatment and disrespect of healthcare providers including verbal harassment, sexual harassment, and physical harassment is relatively commonplace in the clinical setting.
• Per Bureau of Labor Statistics, healthcare professionals are at a 16x greater risk of violence than professionals in other service fields1.
• Much of this mistreatment is from colleagues and superiors2, but a significant portion is from patients and their families with prior studies showing anywhere from 6-67% percent of the mistreatment done by patients or their families3,4,5,6.
• Providers may feel that being mistreated is an expected part of the job7,8.
• Many resources have been dedicated to understanding and decreasing mistreatment amongst colleagues9.
• Studies suggest that mistreatment from patients and their families may be potentially more prevalent than mistreatment from coworkers in the emergency department (ED) setting10.

The objective of this study was to quantify better understand the types of mistreatment directed towards providers and to determine whether or not it was especially prevalent in the ED setting.

Methods

• Residents across nineteen training programs at a single academic medical center were recruited to complete an anonymous survey assessing their experience with mistreatment instigated by patients and families.
• Six unique mistreatment behaviors were adapted from the AAMC Graduation Questionnaire, allowing residents to report behaviors they experienced.
• Emergency Medicine (EM) resident responses were compared against residents aggregated across the other eighteen programs to detect group differences for each behavior using Chi-squared and Fisher's exact test.

Results

• 303 residents out of 428 (71%) completed the survey.
• 40 respondents did not complete the patient mistreatment section and were excluded from analysis.
• Of the 303 respondents, 37 were EM and 266 were non EM.
• There was a significant difference between EM and nonEM residents on:
  • experiencing patient mistreatment at least once during residency (69% EM, 45% nonEM, p=.007, Table 1)
  • being threatened with physical harm (58% EM, 28% nonEM, p=.001, Table 2)
  • being physically harmed, (11% EM, 3% nonEM, p=.034, Table 3)
  • being subjected to offensive sexist remarks (6% EM, 23% nonEM, p=.015, Table 4).
• There was no significant difference between EM and nonEM residents on unwanted sexual advances, racially/ethnically offensive remarks/names, or offensive remarks/names related to sexual orientation (p<.05).

Discussion

• Our study demonstrates that EM residents experience equal or slightly more mistreatment from patients than their nonEM counterparts excepting sexist remarks and names which demonstrated the opposite.
• The low number of female respondents in the EM program is likely the cause of this disparity.
  • Of the 45 residents in the EM residency, only 10 are female, a percentage significantly lower than that of the nonEM programs.
  • Multiple studies have demonstrated that women are considerably more likely to be the target of sexist remarks and names than their male counterparts11-12.
  • Various factors including wait times, crowded facilities, lack of long-term relationships with patients, and many others have been suggested as contributing to increased mistreatment of EM providers13.
• Improved communication between patient and provider has been positively identified as improving patient satisfaction (as well as lowering lawsuits and claims filed)14,15.
• Strategies for communicating with difficult patients that focus on implicit bias training and consensus building have been developed and show some promise16.
  • These strategies have not demonstrated an obvious effect on decreasing mistreatment of EM providers by patients and their families, but offer a potential opportunity to positively affect relations between the groups.
• Studies demonstrate a positive association between harassment with anxiety, depression, frustration, and burnout17-18.
  • These traits disproportionately affect the medical community.
• Interventions to improve the culture of mistreatment in healthcare must be multifocal to fully address the issue.
• Limitations of the study are as follows:
  • Recall bias - the questionnaire was administered as a Barrier to Reporting.
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