PERSPECTIVE

Inappropriate Behavior by Patients and Their Families—Call It Out

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Recently, I was the hospital attending physician on service when the team admitted an elderly patient. Despite the obvious end-of-life status, the family wanted everything done to keep the patient alive. They made unrealistic demands, were disrespectful, and at times were outright hostile. They did not want to work with the medical student, who was Muslim. They also did not want to work with the intern, whom they felt was not a real physician. The senior resident, despite being from a neighboring US state, was not allowed to touch the patient because the family believed that the resident's skin was too dark for an American. To say that this family was disappointed when they learned that I, the attending physician, was a woman would be an understatement. After a brief introduction, I let the family know that we work as a team, and they would be working with all of us. Later when I discussed this out-of-the-ordinary behavior with the team, I asked, "What did you do when you recognized the disrespectful behavior from this family?"

Defeated, they looked at me, and with a collective sigh, they said "Nothing."

When I walk into an examination room, I expect the general interaction to proceed in a predictable manner, and usually it does. Sometimes, however, a patient or family behaves or reacts in an unexpected or outrageous way, which is surprising, shocking, or even confusing. I often find myself stunned, feet weighted, mouth paralyzed. My mind whirls to make sense of the unexpected departure from the customary script. If I am in a room with other professionals, I look for their reactions to guide me. When no one reacts, I wonder "Is it all in my head? Did I really hear that racial slur or that sexist comment? Did I exaggerate it? Am I being too sensitive?"

It is easy to smooth over these occurrences with excuses. "He's from a different generation." "She's ignorant." "He's just stressed being in the hospital." We awkwardly return to the business at hand and lose ourselves in the work. The day presses on, but the nagging memory replays again and again. I think of witty comments I should have made, but they are too late—my audience has left for the day. I kick myself as I replay the encounter, feeling shame for not sticking up for the new nurse, the try-hard medical student, or the patient's burdened spouse. Freezing happens to many of us, as it happened to the members of my team on the night of this admission.

After years of personal paralysis and of recognizing the same paralysis in my team members, I have started to teach boundary setting. On rounds, when others in the room are frozen by a patient's or a family's offensive behavior, I serve as a model by calling out the behavior. Once disruptive behavior is named, the dynamic in the room changes. The behavior loses its grip. It does not like being named, and it does not expect to be called out. I keep the phrasing simple so that when I start to freeze, I have a quick response I can make with minimal thought. "We don't tolerate that kind of speech here," or "Let's keep it professional," or "I'm leaving because I don't feel comfortable" are my standard lines. I address the behavior, set a clear limit, and seamlessly move to the task at hand. While in the moment I use plain language—no arguments, no apologizing or negotiating—when the situation later deserves to be explored, I will circle back to the bedside on my own. This gives me a chance to be curious and learn where a person is coming from by asking why the earlier comment was made. My message to whomever I am correcting is always the same, "I care about you as a person, but I will not tolerate offensive behavior. Now let's focus on how I can help you today."

Practicing these phrases with trainees and medical students, I find that they easily recognize disrespectful behavior, but calling it out is still excruciating. Perhaps this is because they have focused so hard on being "good," achieving the "A" and the letter of recommendation, getting in, and matching for the next spot. Now, in the hospital's crowded hallway, we discuss hyponatremia, diabetic ketoacidosis, and boundary setting. We have informal dress rehearsals so they can practice on me. I role play an inappropriate behavior, for example calling a female intern or nurse beautiful, asking if she's married, asking for her telephone number, and then joking about her blushing. I ask the learner to correct me in real time. Sometimes when they cannot overcome their paralysis, I gently remind them they will not die from being uncomfortable. Setting healthy boundaries for themselves equips them to speak up for team members. Boundary setting has to be practiced to become reflexive. When we practice in a safe environment, we create "muscle memory" of the skills that will protect us when our white coat will not.[1]

I ask the trainees, both men and women, to pick a phrase and practice. Even after my pep talk, sometimes their voices catch as they practice their lines. I am asking them to act counter to who they thought they were supposed to be. I am asking them to find their agency, their voice, to be leaders and demand a safe and respectful work environment. Being a woman in medicine does not mean being small or quiet, flying under the radar, or blending in and not rocking the boat. It means I model boundary setting for our trainees so we can move comfortably both in our places of work and in the community. When we all practice on a regular basis by speaking up to the racial slurs, lewd comments, and hate directed toward a person for their faith, skin tone, or sexual orientation, only then will cultural change happen. We must respond in real time and call out injurious behavior so we can move on to do what we came to do: Be the doctor.

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1. De Becker G. *Gift of Fear: And Other Survival Signals That Protect Us From Violence*. New York, NY: Dell Publishing; 1997.