

## Lotte Dyrbye, MD, on physician mistreatment by patients, families and visitors

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### Featured topic and speakers

In today's episode of Moving Medicine, AMA Chief Experience Officer Todd Unger discusses the mistreatment and harassment of physicians and its effect on physician well-being with Lotte Dyrbye, MD, senior associate dean of faculty and chief well-being officer at the University of Colorado School of Medicine in Denver.

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### Speaker

- Lotte Dyrbye, MD, senior associate dean of faculty and chief well-being officer, University of Colorado School of Medicine

### Transcript

**Unger:** Hello, this is the American Medical Association's Moving Medicine video and podcast. Today we're joined by Dr. Lotte Dyrbye, senior associate dean of faculty and chief well-being officer at the University of Colorado School of Medicine in Denver, to talk about the mistreatment and harassment of physicians and its effect on physician well-being. I'm Todd Unger, AMA's chief experience officer in Chicago. Dr. Dyrbye, I've talked to a lot of physicians over the past couple of years and heard stories about harassment during the pandemic. Because a lot of physicians are out there on the frontline, standing up for science on social media. And this has of course been a very, very politically charged environment. That kind of mistreatment is generally coming from the public and people that physicians

don't necessarily personally know.

But this is going to be different that we talk about today because you just authored or co-authored a study that was published in JAMA that looked at harassment of physicians, not by the public but by patients. Their families and other visitors, which I imagine could be a lot more complicated. And before we get into the details of the study, let's start by talking about just the problem itself and get a little scope on this. Is this something that has surfaced with the pandemic or like so many things, did it exist before the pandemic and either wasn't just talked about as much or got worse?

**Dr. Dyrbye:** It's really a great question and one that we don't really know the answer to. So our study of U.S. physicians across the United States was done about six to nine months into the pandemic. And we asked physicians about their experiences related to mistreatment by patients, families and visitors over the previous year. So the data we collected was really before the pandemic. And as you already brought up the pandemic has really brought different issues, different social issues to the forefront and there have been, unfortunately, many reports in the media about physicians really experiencing harassment and intimidation. Just related to the COVID-19 pandemic, whether it's about hospital visitation rules, about masking requirements and obviously also about vaccines. So I think if anything, we were to repeat the study today and ask doctors about their experiences, it's likely to be even more prevalent than it was really a year before the pandemic.

**Unger:** Did you have a hypothesis going into this study and were you surprised by either the levels of harassment that you saw? Or other aspects of the results?

**Dr. Dyrbye:** Yeah. So there have been studies about mistreatment in general. Mostly in residents and medical students and the majority of that research was really focused on mistreatment within the culture. So by that, I mean mistreatment by other colleagues. Not much had been done about mistreatment from patients, families and visitors. And especially physicians experiences and how that varied by gender and how that varied by race and ethnicity. We did go into it with the hypothesis that physicians who experience this sort of suboptimal treatment to say the least, from patients and families and visitors were probably at higher risk of burnout.

**Unger:** I can imagine that. Just to be a little more specific. What are we talking about here in terms of the harassment? Is this comments, does it go beyond that?

**Dr. Dyrbye:** So really both tied. So in our national study we asked about experiencing racial or ethnic offensive remarks, which you know, about a third of the physicians had experienced. We asked them about offensive sexist remarks, which also about a third experience. But it was more than remarks. It was more than comments. One in five physicians had experienced unwanted sexual advances from patients, families and visitors. A similar proportion had experienced a situation where a patient or a family member had simply refused them to provide care for a patient because of the physician's personal attributes. And in terms of physical harm, that was less common but 15% of the physicians

reported that they had been physically harmed by a patient, family or visitor within the last year.

**Unger:** That is really surprising. I'm going to guess by how you just characterize that, that certain physicians might be more susceptible to this kind of mistreatment. Is that true in what is driving that?

**Dr. Dyrbye:** Yeah, Todd, exactly. As you'd expect, women physicians are more likely to experience mistreatment and harassment really, of all types, that I already mentioned. As we're racial and ethnic minority physicians. So like if you dive into some of the data about 30% of women physician had experienced unwanted sexual advances from patients, families or visitors. In contrast to about 15% of men. But when you look at patients refusing care because of physician's personal attribute, that was also twice as common in women relative to men. And then we see very similar patterns when we look at various racial and ethnic groups in comparison to non-Hispanic white physicians. We took it one step further. So then we also looked at women and men and how they differed within various racial groups. And it's sort of that intersection, right? So if you're a woman who's also a racial or ethnic minority member, you're much more likely to have experienced mistreatment from patients, families and visitors, relative to male non-Hispanic physicians.

**Unger:** It makes me think of a lot of other professions where you see maybe an established code of conduct. Which you don't really think of that as something you really have to say in a hospital or a physician office setting. Is that something that we need more explicit about?

**Dr. Dyrbye:** I think you're right. And that really sort of gets into the where do we go from here? How should organizations respond? And part of that as some institutions have been doing is, is really crafting and implementing a patient and visitor conduct policy and procedures around that. So what do we do as health care workers when we are the receiving end of a bigoted remark, for example from a patient, a visitor or family member. How should we respond in that situation? And these sorts of policies can really help set that expectation and the procedures around that, as well as in what situation do we simply terminate the care of a patient? How do we do that? When can we do that? What are ethical ways to doing that in a way that supports the health care worker and really promotes our values. Right? Of building a diverse and inclusive environment for everybody.

**Unger:** Back to your, kind of the hypothesis and the question I asked about the effect of the pandemic. We certainly know that burnout was a problem before the pandemic and that the pandemic itself ushered in entirely new levels of that, of burnout. You looked at the correlation between now this kind of harassment that we're talking about and burnout. What did you find?

**Dr. Dyrbye:** Yeah. So as we had hypothesized, physicians who experienced mistreatment and harassment at work, that's obviously a work stressor. And physicians who've had these sorts of experiences, they were at higher risk or burnout. So even after you control for specialty type and work hours and a variety of other factors. Being harassed or belittled or discriminated against by patients, families and visitors was an independent predictor of physicians being at higher risk of burnout. And

the more often the physician had had these experiences, the higher their risk of burnouts. So if you had it rarely it increased your risk of burnout by about 20 some percent. But if you'd had these mistreatment experiences often, it increased your odds of burnout by up to 120%. So really staggering impact on people's sense of professional well-being.

**Unger:** I guess I would say those are not surprising statistics in the sense that work is stressful as it is. And if you were to layer on something like harassment onto that, I can only imagine the impact giving the environment physicians are already working in. Was there anything, in addition to this that really surprised you from what you found?

**Dr. Dyrbye:** I mean I didn't find it really surprising that physicians were experiencing mistreatment and discrimination by patients, families and visitors. I am a doctor, I have have been in practice now for many years. Have personally experienced it, I've seen other people experiencing. But what I was really disheartened by was that one in five doctors reported having experienced a situation where a patient or family member simply said, "You can't care for me." Simply because of the way you look or your personal attributes and 40% of Black physicians, Black male physicians have had such an experience in the last year. And I really think that's heartbreaking. That's something that we really need to figure out how to fix so that we can promote an inclusive culture where all clinicians can thrive.

**Unger:** Absolutely. You mentioned you're of course a physician but you also have a role as a chief well-being officer. Have you seen physicians personally experience this type of harassment? And if so, how do you handle situations like this?

**Dr. Dyrbye:** Yeah, it's tough. And there's not necessarily one right way or a great recipe to do it. But in the situations where I've experienced a patient refusing to be cared for by a colleague due to a personal attribute, like a person's race, for example, the first step is really to assess the acuity of the situation, right? This is an emergency situation where the patient is hemorrhaging, you know obviously you need to stabilize the patient, right. Or if it's a situation where the patient's mental capacity is questioned, like they're clearly experiencing delirium, you're going to handle that differently. But all too often these are experiences that are happening in non-acute situations with patients who are competent and there it's challenging in ... Once I overcome the shock of what just happened, it is important just to step back and to explore the patient's beliefs compassionately.

And that's a really hard thing to do but I find that sometimes there's misunderstandings that the patients have that can be kind of corrected in the moment. I find it a good step to really empathetically listen, and then try to use reasoning and redirection. And part of that is simply affirming that Dr. so and so is one of our very best doctors and they're going to provide outstanding care for you. That can sometimes deescalate issues but at times you can't redirect and it becomes really pervasive and the behavior continues.

And in that sort of situation, it's important just to capture direct quotes from what the patient's saying and feed it forward to leadership. And, there I think that leaders, whether it's the DEI officer or the patient experience officer there needs to be a leader within an organization who takes the appropriate steps to ensure that patient abandonment is guarded against. But at the same time that we can provide other options for that individual to seek care at different places and facilitate transfer of medical records, if that's the situation. Or at the very least develop a contract between the patient and the organization so that we can avoid insensitive or intolerant remarks being made toward any member of our staff.

**Unger:** Yeah. It's hard to believe that we do need to be more explicit about that but it sounds based on the results that's seems like something we would have to explore. I mean given the nature of the findings from your research, the impact that it's having on physicians and the staff. What is your advice to physicians and to other systems out there who might find themselves in a situation where they're being harassed by a patient or a family member?

**Dr. Dyrbye:** Yeah, I think many of the same principles apply. Assessing the ... situation, considering the patient's mental capacities and then exploring beliefs with compassion but also really standing firm and what the values are. And then feeding information forward to leadership and situation where the behavior continues. But beyond that I really hope that individual seeks support. This is incredibly traumatic and stressful as we've already talked about. It increases the risk of burnout. So I really hope that physicians who have such experiences are seeking peer support or having conversations with colleagues about this experience. Sort of working through those emotions and making sure that procedures and policies are in place within an organization. To try to reduce the frequency of these things happening and really building support around the individual who has such a work-related experience.

**Unger:** And like so many issues that surround burnout are system-level factors. Are there any other changes that need to happen at that level so that physicians feel supported and protected in this case?

**Dr. Dyrbye:** Yeah, it really needs to be a coordinated strategy. So for example, a physician might be reluctant to say something because they are then worried about what might happen from a patient experience perspective, right? So there needs to be a coordinated strategy between operational leaders, security leaders, people in the occupational workspace. Chief diversity officers, as we already talked about. Chief well-being officers. Some organizations also have workplace violence leaders and I really think getting these individuals together to say, okay, what are some strategies that we can allow within our organizations to really reduce the frequency of these sorts of experiencing happening to our staff. And building support systems when they do happen to mitigate their impact. And that really takes collaboration across these multiple different groups within an organization.

**Unger:** Well given the power of what you have learned and the results of this particular study, I have to imagine that you are going to go and explore this a little bit more deeply since this really is one of the first studies that looked at this type of harassment and effect on physicians. What other data would you like to see in order to make changes going forward?

**Dr. Dyrbye:** So we need to learn more about what are effective strategies, right? So I talked about policies and procedures like patient/visitor conduct policies. Well, okay. How well do they work? What do they need to include in order to work? That's one line of inquiry that I think is very worthwhile to pursue. And similarly, we talked about, okay, we need to offer peer support in systems to help the individual who does experience discrimination harassment from patients, families and visitors. And what should that look like in order to be effective? So, yeah, we definitely need more research so that we can get to what I really call the now what, right. How do we reduce these events from happening in the first place and how do we respond better? So that the impact on the individual isn't as severe.

**Unger:** Well Dr. Dyrbye, thank you so much for shedding light on this really important topic and for all the work that you're continuing to do to support physician well-being. That's it for today's Moving Medicine episode. We'll be back soon with another segment. You can find all our videos and podcasts at [ama-assn.org/podcasts](https://ama-assn.org/podcasts). Thanks for joining us today and please take care.

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