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Who Protects Clinical Learners in Canada? Ethical Considerations for Institutional Policy on Patient Bias

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Article abstract

Navigating the social dynamics of clinical spaces can be an added challenge to the complexities of clinical work. Acts of bias and discrimination from patients have been found to affect healthcare workers both physically and psychologically. As more attention is paid to addressing discrimination by patients, we raise attention to the experiences and unique needs of clinical learners. Given that learners play a vital role in the functioning of hospital ecosystems, we advocate for the inclusion of their voices in any revision to policy and practice. In this paper, we critically examine the academic literature on learner's experiences with mistreatment from patients, and their families. We outline the major gaps in policy, process, training, and institutional culture, noting the urgent need for institutions to address these gaps in ways that are meaningful to learners. Our goal is to highlight the lack of bioethics attention to this matter and propose areas where we can add value and support. With this goal in mind, we present a series of tables with guiding values, ethical considerations and questions for institutions.

Who Protects Clinical Learners in Canada? Ethical Considerations for Institutional Policy on Patient Bias

Sun Drews[a,b], Claudia Barned[b,c,d]

Résumé

Naviguer dans la dynamique sociale des espaces cliniques peut être un défi supplémentaire aux complexités du travail clinique. Il a été démontré que les actes de partialité et de discrimination de la part des patients affectent les travailleurs de la santé à la fois physiquement et psychologiquement. Alors que l'on s'intéresse de plus en plus à la discrimination par les patients, nous attirons l'attention sur les expériences et les besoins uniques des apprenants cliniques. Étant donné que les apprenants jouent un rôle vital dans le fonctionnement des écosystèmes hospitaliers, nous préconisons d'inclure leur voix dans toute révision de la politique et de la pratique. Dans cet article, nous examinons de manière critique la littérature académique sur les expériences des apprenants en matière de mauvais traitements de la part des patients et de leurs familles. Nous soulignons les principales lacunes en matière de politique, de processus, de formation et de culture institutionnelle, ainsi que le besoin urgent pour les institutions de combler ces lacunes d'une manière qui soit significative pour les apprenants. Notre objectif est de mettre en évidence le manque d'attention acordée par la bioéthique et de proposer des domaines dans lesquels nous pouvons apporter une valeur ajoutée et un soutien. Dans cette optique, nous présentons une série de tableaux contenant des valeurs directrices, des considérations éthiques et des questions à l'intention des institutions.

Abstract

Navigating the social dynamics of clinical spaces can be an added challenge to the complexities of clinical work. Acts of bias and discrimination from patients have been found to affect healthcare workers both physically and psychologically. As more attention is paid to addressing discrimination by patients, we raise attention to the experiences and unique needs of clinical learners. Given that learners play a vital role in the functioning of hospital ecosystems, we advocate for the inclusion of their voices in any revision to policy and practice. In this paper, we critically examine the academic literature on learner's experiences with mistreatment from patients, and their families. We outline the major gaps in policy, process, training, and institutional culture, noting the urgent need for institutions to address these gaps in ways that are meaningful to learners. Our goal is to highlight the lack of bioethics attention to this matter and propose areas where we can add value and support. With this goal in mind, we present a series of tables with guiding values, ethical considerations and questions for institutions.

Mots-clés

patients racistes, mauvais traitement des apprenants, préjugés des patients, apprenants cliniques, bioéthique, politique institutionnelle, enseignement des professions de santé, soins de santé au Canada

Keywords

racist patients, learner mistreatment, patient bias, clinical learners, bioethics, institutional policy, health professions education, Canadian healthcare

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INTRODUCTION

The detrimental impact of racism has received much scholarly and applied attention across various disciplines and professions over the last three years. Following the 2020 public murder of George Floyd, an African-American man brutally murdered by police in Minnesota, USA, and the nationwide outrage in Canada over the 2020 death of Joyce Echaquan, an Atikamekw woman who died as a result of being subjected to racism and a lack of proper care during a hospital stay in Quebec, many within Canadian healthcare have called for greater scrutiny to the harm caused by structural and interpersonal acts of discrimination and oppression. Clinical spaces are not exempt from such acts; in fact, they ought to be viewed as microcosms of society – experiences of discrimination are not left at the doorstep of the hospital but rather permeate the walls of the institution. In these spaces, bodies of difference are surveilled and scrutinized in ways that often amount to experiences of inequity.

Bioethics, like medicine, nursing, occupational health, and social work, has been called to turn its gaze inward to examine the harms that are caused by the whiteness of the field and the lack of attention to the lived and material reality of discrimination in healthcare. There are topics within the bioethics realm that, to-date, have not received sufficient attention despite the inherent ethical spaces they occupy. One such topic is the ethics of patient bias – e.g., discriminatory requests and refusals of care from patients, verbal or physical actions or statements rooted in discriminatory attitudes or beliefs – that are based on the social identity of the clinician. The academic literature on patient bias is dominated by scholarship on patients as the *targets* of discrimination, but very little attention has been paid to patients as the *source* of discrimination. Studies that have explored

discrimination from patients predominantly focus on the harrowing experiences of medical professionals, with some attention to the plight of physician learners. Clinical learners across the health professions are particularly vulnerable to discriminatory behaviours given their junior status and the power imbalances that are associated with their roles. Despite legal obligations to protect learners from physical and non-physical harms, including dignitary harms, inadequate organizational responses contribute to the overwhelming silence that learners tend to endure after experiencing bigoted behaviour from patients.

The aim of our paper is to challenge this culture of silence by drawing attention to the nuances of learners' experiences with patient bias. Our aims are threefold: first, we provide a critical review of learner experiences in hospital settings; second, we examine notable barriers and challenges faced when responding to patient bias; and third, we outline individual and institutional responsibilities necessary for the protection of learners. We conclude with an overview of the policy, process, and training gaps in this area and then outline the ethical values to weigh, and questions to consider, when examining what protection, training, reporting, and support for learner mistreatment ought to entail.

The Experience of Clinical Learners in Hospital Settings

Clinical learners play a vital role in the functioning of hospital ecosystems. Navigating the social dynamics of clinical spaces can be an added challenge to the complexities of clinical work. Although the experiences of clinical learners in teaching hospitals is a relatively understudied area, the experiences of medical students, residents, and fellows are captured in the wider academic literature (1-11). An obvious gap in this scholarship is information about or examination of the experiences of non-physician learners, that is, in other health professions such as nursing, occupational therapy (OT), physical therapy (PT), respiratory therapy, and social work (12-18). This gap applies to the broader literature on the topic, as well as more specifically to academic scholarship on the experiences of health professions learners in Canada.

The few reports that exist regarding the experience of clinical learners in Canada focus on physician learners as the primary source of data. The "Voices" surveys – Voice of the Medical Student, Voice of the Resident, and Voice of the Clinical Fellow (19) – seem to be the primary tools used to garner feedback on the clinical experiences of medical learners in Canada. While these surveys are helpful in shedding light on the experiences of physician learners, they also highlight the critical gaps in broader understandings of learner experiences in Canada. For example, there has been little attention to how racialized[1] clinical learners in the nursing and allied health professions may be uniquely affected by patient, family, and visitor mistreatment (19). Further, a lack of attention to Indigenous learner experiences points to the ongoing erasure of Indigenous experiences in Canadian healthcare research and education.

The misconception that discrimination and systemic oppression are uncommon problems in Canadian healthcare, and healthcare education more broadly, can be attributed in part to the preceding and prevailing whiteness of the medical field and healthcare leadership more generally (7). In reality, harassment and discrimination are dominant themes of the clinical learner experience (21). In a study conducted at the University of Toronto Temerty School of Medicine, 54% of residents and 46% of fellows reported experiencing harassment or discrimination during their clinical rotations (21). Furthermore, 49% of medical residents identified patients and their families as the primary source of this mistreatment (21). Data from the 2019 "Voice of the Resident" and "Voice of the Clinical Fellow" surveys revealed that, of the respondents, 64% of physician residents and 39% of fellows across hospitals and clinical programs reported exposure to incivility including, but not limited to, disrespectful behaviour, verbal assault, bullying, sexism, racism, classism, Islamophobia, antisemitism, sexual harassment, threats of physical harm, and assault throughout the course of their previous year's training (21).

Despite discrimination being a consistent theme of the medical learner experience in the Toronto context, nuanced qualitative accounts on the nature and extent of these experiences are lacking. A scan of the wider literature reveals some phenomenological accountings in other geographical contexts (2,4,5,9,11,22-30), yet these tend to be narrowly focused. The existing work in this area examines the impact of discrimination on learners (9,15-18,22,25,31,32), the differential experience for minoritized learners (2,4,5,9,11,13,15,18), the difficulties in responding to discrimination (3,5,7,8,9,11,15,17,26), barriers to reporting (5,9,14), and the lack of institutional resources and support from clinical supervisors (7,15,18,30,33). We explore the nuances of each of these issues, below.

Acts of bias and discrimination from patients have been found to affect learners both physically and psychologically (9,25). This includes experiences of stress, fatigue, emotional distress, and trauma that often lead to decreased job satisfaction, burnout, withdrawal from practice, distracted learning, and an inability to focus on professional development (9,16,17,22,31). The psychological impact of patient bias has been described as "a long-term, well-ingrained sense of humiliation" (16, p.716) that accompanies feelings of fear, uncertainty, rejection, exclusion, and cynicism (9). These experiences can and often do contribute to imposter syndrome amongst learners (2,3,32), whereby one constantly questions one's ability, belongingness, and capacity to succeed in a program.

While all learners might experience discrimination from patients in some form (including discrimination solely because of their identity as a learner), racialized learners, and those who embody difference (relative to the white, cisgender, heterosexual

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[1] The term 'racialized' is applied here and throughout the text to acknowledge that race is a social construct (20). Historically and contemporarily, racialization has been weaponized as a process to separate Black, Indigenous, and People of Colour (BIPOC) from the dominant white group to uphold a system of white supremacy. We recognize that in some contexts, 'white' may also be racialized; however, for the purposes of this manuscript, we use the term to refer to non-white groups.

male prototype) tend to be disproportionately targeted (5). Learners who identify as women, and those who identify as Black, Latinx, Asian, and Muslim experience a higher rate of misidentification, role-questioning, racial slurs, physical and verbal abuse, sexual harassment, and refusals of care (2,4,5,9,11,13). Biased reassignment requests or refusals of care from a patient's substitute decision-maker, family member or essential care partner also occur but are seldom documented (1,9,10,14,34). Despite observations that biased refusals of care are more commonly made by family members than by patients themselves (16), the nuance and veracity of this claim remains unexplored, particularly in relation to clinical learners. Furthermore, literature documenting patient bias policies across health systems and institutions remains relatively sparse and contains very few concrete steps or specific processes (as well as roles and responsibilities) for handling these interactions when problematic behaviours are directed toward learners (34,35).

The personal accounts of clinical learners convey the gravity of this issue and the urgency with which incidents of bias from patients and/or their family members ought to be addressed. The few personal narratives recounted in the wider literature reveal that clinical learners have experienced both physical and verbal assaults as well as degrading and demeaning behaviours (30,33). For example, Bonsu recounts her experience having a patient spit at her, try to bite her hand, and scream "Get off me, you dirty Black monkey!" (33, p.1462). Williams and Rohrbaugh describe a patient's use of the N word being repeatedly weaponized against Williams while training as a resident physician (30). Despite attempts to redirect the patient with compassion, the patient refused to acknowledge Williams' presence or even his humanity (30). Sadly, in each of these incidents, the supervisor did not address the patient's behaviour, nor check-in with the learner to offer support or inquire into how they wanted it to be addressed (i.e., whether they wanted to be removed from the patient's case). These types of experiences are not new, nor are they reserved for Black learners. Others have reported on the prevalence of patients demanding to be seen only by a white doctor (26) or explicitly refusing care from clinicians of a particular ethnicity, e.g., patients expressing that they "do not want an Arab to touch" them (16, p.715). In addition to refusals, racialized physician learners described having their medical credentials questioned by patients (26) and female physician learners reported having their role questioned so often that it hindered their ability to do their jobs (22).

Similar to the aforementioned physician leaner experiences, learners from other disciplines report refusals of care and verbal abuse in the forms of threats, racism, swearing, and sexual insults (13-15,18,36). It has been argued that nursing staff (especially nursing students) are subjected to biased refusals of care and abusive behaviour more often than physicians due to the high frequency and closeness of interactions with patients and families (16). Additionally, the culture of sexualization towards nurses may result in nursing students being particularly vulnerable to sexual harassment in comparison to learners from other disciplines (12,13,37). Nursing students have reported extreme cases of verbal abuse from patients and their families during clinical placements, often involving racial and sexual connotations (13). The nursing students in Ferns and Meerabeau's study describe being told "I don't want any Black monkey to come to my bedside, f… off', being called "a dirty whore" and being told "...all nurses should be f...ed to show them who's boss" (13, p.440).

In addition to being sexualized, some learners, based on the nature of their discipline, might also be more likely to experience physical acts of aggression or unwanted touching from patients. For example, learners from disciplines that embed movement in their approach to care (such as PT and OT), might experience the added dimension of unwanted physical contact from patients. Steinkamp's study with 'underrepresented minority' PT learners highlights how unwanted touching from patients can sometimes be entwined with the provision of care (18). A PT learner in the aforementioned study described her experience as follows:

> I was treating an older White woman with an ankle sprain. She grabbed and rubbed my hair and said 'Wow, your hair is just so fun.' I was immediately taken aback. My clinical instructor (CI) and I talked about how what she did was inappropriate. I saw the same patient 2 more times, and she touched my hair both times and made a remark about how it felt. I felt very uncomfortable with this. My CI had stated that they would intervene if it happened again, but they did not. Looking back, I should have said something right away to stop this behavior; however, I did not know how my CI would respond to me doing so (18, p.S63).

The discomfort experienced with such an encounter can be destabilizing for learners, especially if the incident is not addressed by their supervisor.

RESPONDING TO BIAS

Multiple barriers exist for learners when deciding whether and how to respond to incidents of patient bias; these include: 1) feeling a need to prioritize clinical care, 2) experiencing uncertainty in their ability to respond effectively, 3) sensing an absence of support from their team, supervisors, and organization, and 4) lacking knowledge concerning related policy (9). Additionally, learners' junior status within the conventional medical hierarchies, their limited experience, clinical autonomy, and confidence in their roles restrict their ability to respond when subjected to biased patient conduct (11,26). As a result of these barriers, many clinical learners compartmentalize experiences of bias, avoid confronting them directly, and continue to care for patients at the expense of their own safety and personal dignity (3,5,8,9).

Responding to these instances can be just as difficult as it is to endure them in the moment, particularly for racialized learners. They might feel voiceless in responding to acts of bias or feel that they cannot react in ways that protect their dignity because of the pressure to be perfect and perform at a higher level than their white colleagues (7,8,15,17). It is likely that they also

undergo a different level of scrutiny insofar as societal biases inform how trainees are evaluated (38). Racialized learners describe feelings of exclusion, isolation, and a lack of support and recognition within the clinical education setting (7). Some make calculated decisions to downplay their identity including disguising visible identity markers to reduce the frequency of indignities experienced (8,17). These experiences disadvantage racialized learners, leading to higher turnover rates and greater academic disparities that hinder professional development as well as institutional attempts to bolster diversity and inclusion within healthcare professions and leadership (2,3,32).

The aforementioned points are directly applicable to the experiences of Black learners. Black physicians in Ontario, for example, report that experiences of overt racism and prejudice from patients were routinely unaddressed or dismissed by their white supervisors during their medical training (7). This is the case, despite there being higher reported rates of mistreatment among Black and Indigenous learners, other racialized learners, women, individuals identifying as 2SLGBTQIA+, members of minoritized faith groups, and learners living with a disability (21,39). Leaving these incidents unaddressed results in learners feeling unsafe, excluded, and isolated, and contributes to a general reluctance to report incidents of patient bias (7,21). Approximately 95% of Black physicians who reported experiences of race-based mistreatment had not received training on how to respond to such incidents and consequently internalized or ignored negative encounters (7,40). Over the course of their training, some Black physicians sought support and guidance from other Black colleagues, as well as family and friends (7). As a result of this self-directed coping, they developed strategies to self-advocate and the skills needed to respond directly to verbally abusive and biased patients (7).

When learners feel confident and supported to respond directly to acts of bias, they report setting limits, developing plans with their teams, and explaining to patients the effect of biased behaviour on their clinical care (5,9). Some learners report that they debrief biased incidents informally with colleagues, friends, and family members (5,7,9). Responding effectively is associated with improved feelings of competence and a greater sense of inclusion within the team and profession (9). The ability to navigate these interactions is a skill that must be taught and ought to be embedded in clinical education, as is the case with other clinical competencies.

Pean and Hart maintain that it is unethical for clinical learners to capitulate to discriminatory conduct by patients, thereby sacrificing their own dignity in the service of a problematic ideal of clinical neutrality (26). In a healthcare context, any approach to biased patient conduct or reassignment requests must consider the acute care needs of the patient as different clinical contexts necessitate different responses (25,34,41). For example, responses to patient bias in the emergency department generally would entail different considerations than might a rehab context. Furthermore, different contexts might invoke varying degrees of altruism on the part of the healthcare worker. In emergency contexts, where the focus is on stabilizing the patient, one might argue that patient safety should be prioritized over staff wellbeing. The tension between patient needs and healthcare workers' rights is further complicated when applying Ontario's human rights code (42). Though there are further nuances to unpack within the context of occupational health and safety, healthcare workers cannot be made to endure continued exposure to violence, harassment, or discrimination as this would constitute a contravention of employee rights (42). The same argument applies to learners' rights to train in a discrimination free environment.

The motivation of clinical learners to prioritize the clinical needs of the patient, and in many cases, the therapeutic relationship over their own dignity and well-being (9), reflects medical cultural norms and an ethic of care (43). This is further amplified for learners in caring professions, such as nursing, in which having empathy for patients is expected and any act of assertiveness in the face of abuse can be interpreted as uncaring (14). Expectations of resiliency and self-sacrifice are normalized within healthcare culture; for racialized clinicians, this often means bearing personal humiliation and overlooking violations of personal dignity in order to compartmentalize emotions and proceed with biased patient encounters (26,33).

Learners may or may not report harmful incidents based on the severity of the violation experienced and the emotional labour that is required to escalate the concern (5). Deciding whether, when, what, how and to whom to disclose or report experiences of bias is a common challenge reported by learners (5,9,14). Some describe feeling reluctant to report incidents of patient bias due to an array of institutional and interpersonal barriers (5,14). These include: 1) the perception that no positive change will follow, 2) a lack of support from supervisors and leadership, 3) feeling compelled to prioritize clinical care, 4) fear of appearing unprofessional, and 5) a sense that the emotional burden of pursuing a claim is too high (5,9).

INDIVIDUAL AND INSTITUTIONAL RESPONSIBILITIES TO CLINICAL LEARNERS

Targeted pathways addressing bias toward clinical learners ought to include consideration of the unique vulnerabilities and power differentials at play. In a competitive training environment, learners, as temporary members of the interdisciplinary team requiring evaluation for completion of their program, are limited in the extent to which they can safely advocate for themselves (31). Given their unique vulnerabilities, there ought to be both individual and institutional protections in place to safeguard against dignitary harms and other violations. Individual and institutional responses to bias take many forms. Examples that offer varying levels of protection to clinical learners include patient reassignment and the use of behaviour contracts as a means of enforcing compliance (9). However, despite the common use of these contracts within health systems, there is little evidence of their efficacy; instead, they raise concerns about health equity, accessibility, and patient-centred care (44). The false sense of resolution that may come with implementing ineffective responses to patient bias risks the safety and well-being of clinical learners.

Supervisor and institutional responses to biased reassignment requests are variable and typically take either a zero-tolerance approach that entails: 1) refusing to replace a practitioner and leaving the patient to accept the decision or to seek care elsewhere, or 2) accommodating the patient's request, often on an ad hoc basis, without providing an ethical justification for the decision (16).

Appropriate and effective supervisor responses to bias or discriminatory reassignment requests ought to demonstrate respect for targeted learners and endeavor to prevent further harm or trauma (31). How, when, and to whom one responds all affect the ability of learners to thrive in the clinical setting. Actions that empower and support learner autonomy are most needed in these situations. Such acts can include: 1) checking in with learners who have been targeted by patient bias, 2) consulting with them in order to respond appropriately, 3) soliciting their consent for patient reassignment prior to acting (35), 4) showing support publicly and privately in the face of such acts, and 5) offering opportunities to debrief or unpack the experience with additional supports. Protecting clinical learners from patient bias through policy, guidelines, and training is the joint responsibility of academic institutions and partnering healthcare facilities. Organizational silence in the face of patient bias is tantamount to complicity and reinforces existing inequities. Stewardship of clinical learners' well-being, including their learning experiences, requires that hospitals, universities, and professional colleges commit to and collaborate in advocating for legislative protections for learners, systemic change, and social justice.

GAPS IN CONSIDERATIONS: ASKING CRITICAL QUESTIONS

As awareness of persistent institutional racism and other forms of systemic discrimination continue to surface at the forefront of institutional consciousness, a number of publications in the academic literature have focused explicitly on the gaps that currently exist and the changes that can be made. These gaps tend to be structured around the need for policy, better processes for handling patient bias, adequate training to respond to bias, and efforts to improve the culture of institutions. Table 1 below offers areas for improvement according to each corresponding gap.

Table 1: Recommended Areas for Improvement by Corresponding Gap

Gaps	Recommendations for Improvement
Policy	• Consistent guidance is needed to navigate the practical, ethical, and legal aspects of biased patient conduct and reassignment requests. This should include transparent and accessible mechanisms for reporting, reviewing and responding to data on biased incidents (5,26,30).
Process	• Robust, accessible reporting structures should be available to all staff and learners (45). This could include a designated committee or office for reviewing incidents of patient bias to ensure accountability for organizational response, adherence to policy and processes, a mechanism for data collection, and support for targeted learners (34). • Institutions should have transparent data collection processes that uphold values of privacy and security (23,30,45). • Institutions should disseminate findings that identify high risk areas and promote organizational accountability (23,30,45).
Training & Resources	• Tailored training should be provided to learners, educators, supervisors, and bystanders, indicating how to identify and respond to incidents of patient bias. This would include education about policies, processes, and support resources (5,16,30,31). • Scripts can be drafted to help learners redirect and de-escalate racist patients, to correct and set limits, and to safely refuse further assessment of the patient (30). • Training should be provided to learners and educators, as well as managers and supervisors, on how to lead safe and effective debriefs following incidents of patient bias (30). • Learners and supervisors should be provided with resources that identify internal and external support resources for those subjected to patient bias (5,31). • Healthcare organizations and academic institutions should share responsibility for the safety and well-being of clinical learners by integrating anti-bias education throughout training programs, and by tracking and responding to bias incidents, providing support to targeted learners, and fostering a culture that values diversity and inclusion (30).
Culture	• Institutional culture should address discomfort with conversations on bias, discrimination, and racism in healthcare (35). • Healthcare organizations should explore whether their culture exceptionalizes patient preferences without striking a balance between patient needs and staff and learner safety and well-being (34). • Visible leadership endorsement of anti-discrimination initiatives and promotion of a just and equitable organizational culture that protects and supports learners is needed to promote an equitable and inclusive environment (34). • Institutional leaders should acknowledge the hierarchical nature of healthcare education by noting that it raises barriers for clinical learners to address and report incidents of patient bias. Reporting should be encouraged without fear of retaliation, damage to reputation, or influence on evaluation (5,24). • Leadership should support recruitment and retention efforts to increase diversity and representation in all educational and professional stages of all healthcare professions (17). • Leaders and supervisors should acknowledge the influence of a healthcare culture that upholds implicit expectations of infallibility, toughness, self-sacrifice, and unwavering empathy within medical, nursing, and the allied health professions. This includes consideration of the impact of this culture on the mistreatment of learners, specifically racialized learners, within academic healthcare settings (14,31).

The aforementioned gaps noted in the literature are directly applicable to the Toronto, Ontario context. The need for clear policy, processes, training, and a broader culture shift has been highlighted in local change initiatives (7,19). In fact, Ontario learners have explicitly expressed a desire to raise awareness about the prevalence and impact of racism within Canadian healthcare and health professional education (7). Small steps have been made towards this goal. For example, in 2022, the Temerty Faculty of Medicine at the University of Toronto published the "Black at Temerty Medicine" report to raise awareness

of the many ways in which anti-Black racism manifests within medical education. This report has since informed initiatives to target anti-Black racism within the Faculty of Medicine and could be used as a model for similar efforts aimed at calling attention to other insidious forms of discrimination and oppression that are active in Canadian medical education, most notably, anti-Indigenous racism. Not only are Indigenous knowledge systems, narratives, and lived experiences typically erased from medical education, but most (if any) inclusions are framed around harmful stereotypes that work to perpetuate negatives images (46,47,48). Accounting for difference in an inclusive way, noting the many lived realities and intersecting identities of people, and accounting for the experiences of non-physician clinical learners is a small first step towards addressing the critical gaps in our response to learner mistreatment in Canadian healthcare.

When discriminatory refusals of care are not handled appropriately, questions about the ethical climate and culture of the institution are justified. Most healthcare organizations have policies on how to address workplace violence and these generally include processes for documenting and reporting these incidents (e.g., through incident reporting systems via the institution's Safety Services department). However, patient bias and discriminatory requests or refusals of care have historically existed in a grey zone with policies specific to patient bias only recently starting to gain traction from a health systems perspective (34,35). Unfortunately, the same cannot be said for policies that solely attend to patient bias directed towards learners. Patient bias policies typically cover healthcare workers or staff members who are employed in the healthcare institution. Given that learners are affiliated with a home university or college and rotate through hospitals and other sites for their clinical placements, the nuances of their experiences, and their specific needs, tend to be overlooked in institutional health policy.

Initiatives that aim to redress the lack of guidance specific to learner mistreatment are underway for Ontario learners and educators. The Toronto Academic Health Science Network for education (TAHSN-e) recently developed a guide for faculty, supervisors, and learners to use as a resource when navigating and responding to incidents of learner mistreatment by patients, family, and visitors (49). The University Health Network (UHN), a TAHSN-affiliated hospital, has advanced its efforts in providing oversight and direction to all parties involved. Their new guidance document on learner mistreatment (50) draws on the TASHN-e guide as well as UHN's Caregiver Preference Guideline (51) to outline a process for UHN staff and physicians to prepare for and respond to incidents of learner mistreatment. This guidance document, along with UHN's Caregiver Preference Guideline, work to provide all members of UHN with appropriate guidance on how to navigate instances of patient bias, with the latter also addressing the ethics of discriminatory requests and refusals of care (51). Although UHN's Caregiver Preference Guideline is currently being revised to account for gaps in system responses that might contribute to non-physical harm towards staff or patients, these two documents share a commitment to the important task of documenting incidents as a means toward comprehensive data collection. Without knowing the prevalence and impact of these experiences, it is difficult for institutions to address the issue in ways that are meaningful to those confronted with and affected by mistreatment.

Mistreatment of learners and staff by patients, family members, and visitors should not be an issue that is addressed only by a select few (e.g., Bioethics departments or Clinical Education offices). There are institutional obligations that must be attended to by others stakeholders across the organization. For example, for patient bias incidents to be captured accurately and in ways that result in data that is actionable, there must be proper incident reporting forms and systems in place that recognize and account for the multiple ways that bias might materialize. On a broader level, non-physical harm (e.g., racism and other forms of discrimination) needs to be given the same level of credence and weight as physical harm when considering safety incidents across health systems. Non-physical harm events should also be formally recognized as workplace hazards and treated as such by Occupational Health and Safety departments. In addition to obligations from Safety Services, and Quality and Safety departments, Human Resources has a key role to play in ensuring that there are adequate structures, supports, and resources in place to protect staff and learners from both physical and non-physical harm. There are also legal obligations that must be attended to when ensuring that a workplace or learning site is free from discrimination (as per Ontario's Human Rights Code) (42). These points highlight that all stakeholders have a role to play in ensuring that hospitals, as sites for the receipt and provision of healthcare, are safe and discrimination free for all who work, learn, and access care.

Given that the principles of equity and justice are deeply embedded in the fabric of bioethics, we maintain that there is a special role for bioethicists in this matter. Bioethicists are well suited to address concerns of bias and mistreatment given the core skillset required for healthcare ethics consultation (e.g., conflict resolution, mediation, negotiation, and facilitation of public engagement) (52). These skills are often used to help establish and, in some cases, re-establish trust between patients and healthcare providers, or other parties that have become divided by acts engendering mistrust (52). Bioethicists also have a role in the development of fair and equitable policies and any resulting policy analysis. More specifically, bioethicists can help ensure that the lived experiences and perspectives of learners and staff are reflected in all policies that directly affects how these groups are treated in the organization.

Patient bias and discriminatory refusals are often jarring and traumatizing and can psychologically harm both the affected clinician and the quality of care provided. Addressing these incidents in a meaningful and effective way is an underexplored area of ethical interest and warrants deeper research and policy attention. In the section below, we present two tables that offer various considerations for those embarking on policy development or framework creation for handling learner mistreatment. Table 2 lists guiding values and ethical considerations to weigh. Table 3 is a series of guiding questions to reflect upon when considering what protection, training, support and reporting ought to look like within the context of learner mistreatment.

Table 2: Guiding Values and Ethical Considerations

Values	Ethical Considerations
Beneficence/ Non-maleficence	• What are the short- and long-term effects of mistreatment on learner wellbeing and their education? • What is the effect on the learner's ability to navigate similar interactions during the rest of their clinical placement? • What are the obligations of specific institutions to address harms to learners? How might these differ based on site (i.e., university versus hospital)? • How might the type (and size) of institution affect the level of resources available to address harms and provide support to learners? • How might the reputation of each institution be damaged if learner mistreatment is not handled appropriately? • What are potential short- and long-term consequences for learners if mistreatment is not addressed appropriately? • How does status as a learner influence their ability to access employee hospital supports when facing mistreatment? What potential harms might arise from the lack of such access? • What are the potential consequences of seeking university support when learner mistreatment occurs in the clinical setting?
Equity	• Which groups of learners are likely to be subjected to mistreatment? • What added protections need to be implemented for learners from equity-deserving groups? • Have academic and healthcare institutions considered the direct and indirect needs of learners when faced with mistreatment? • What mechanisms are in place to capture learner specific needs with respect to mistreatment? • What equity-related considerations need to be attended to when capturing learner specific needs? • What conditions are in place to ensure that learners from equity-deserving groups feel safe to explicitly share their needs? • What support mechanisms are available to learners who encounter triggering situations that are not recognized as such by their supervisor? • How might programs avoid exacerbating existing disparities? • What potential barriers are learners likely to encounter? What steps will be taken to remove them?
Fairness	• What opportunities are available for learners to prepare themselves to respond to these situations effectively? • How might these experiences affect the clinical experience and education of marginalized learners compared to others?
Transparency	• How is information on the nature, frequency, and prevalence of mistreatment experiences made available to learners prior to the start of their placements? What information is made available regarding institutional procedures and supports for handling learner mistreatment? • How can institutions effectively address learners' apprehensions about potential repercussions associated with reporting mistreatment? What assurances will be provided to foster a safe and supportive environment for voicing concerns?
Accountability	• Who is responsible for protecting learners? Within program structures, are there designated leads who are accountable for ensuring learners have a pathway to report mistreatment? • Are there established accountabilities at professional colleges or associations concerning how learner mistreatment ought to be handled? • Are there other partnerships that ought to be involved in the university-hospital relationship to enhance learner protection at a broader level?
Privacy	• How are learners' privacy rights safeguarded when incidents occur? Who is the incident shared with so that it is escalated via the right channels while also protecting the learner from unintended consequences? • When incidents occur in the clinical environment, are reporting relationships structured to ensure that the university or professional school is informed of the incident in a manner that allows them to provide needed supplemental support, whilst respecting the learner's privacy?
Reciprocity	• What are the learner's expectations of the clinical environment? • What are the learner's expectations of their supervisor's ability to recognize and attend to mistreatment? • Given the partnership between educational institutions and the healthcare environment, what can learners reasonably expect in terms of protection from unsafe or traumatizing experiences? • What responsibilities do institutions have in terms of providing learners with safe environments for their learning and educational activities? • Do institutions meet the expectations learners might have for a discrimination or mistreatment-free environment?
Stewardship	• If learners are removed from particular interactions, are there steps to ensure that they are given opportunities to be involved in other cases? How will the learner's education be supplemented to ensure that there are no gaps in their exposure to particular cases, programs, clinics, types of care provision?

Table 3 below presents guiding questions for institutions to reflect upon when considering training, reporting mechanisms, and supports that ought to be made available to help learners navigate incidents of mistreatment.

Table 3: Guiding Questions for Institutions

Themes	High-level Questions	Example Considerations
Protection	● What does protection look like for clinical learners?	● What do learners consider adequate protection or appropriate responses to mistreatment? ● From an equity lens, what might protection look like for racialized learners or those from underrepresented groups? ● Are there learner-informed materials and processes that consider the nuances of their lived experience as well as the tensions associated with power differentials? ● Are learners made aware of organizational policies, their legal rights and protections, as well as any other available resources prior to the start of their placements?
	● What are the obligations of the institutions involved: 1) university, 2) hospital 3) college, etc.?	● What institutional processes are there to protect against these types of experiences? ● Are there mandatory legislative obligations that include protections for learners? ● Are there services or supports, akin to WSIB protections for workers, that provide protection for learners? ● Are there learner-centred policies that capture this issue? ● Does the clinical education department cover all the necessary education prior to and during the placements? ● Are learners aware of the various reporting mechanisms available to them? ● Do learners know who to approach when incidents of mistreatment occur, and do they feel safe enough to speak up when situations arise? ● Does each institution have a confidential or anonymous process for safe reporting? E.g. Whistleblower hotline? ● Does each institution have a safe-haven program for clinical learners to feel safe in accessing support?
Training	● What training needs to be available for supervisors to ensure that they understand and appreciate the experiences of learners? ● What training needs to be available for supervisors to ensure they are capable of providing appropriate supports and resources? ● What training needs to be developed to teach learners how to navigate such instances in the moment? (Particularly important where there might not be a supervisor present).	● Supervisors should be able to recognize the differential impact of harmful interactions on racialized learners and acknowledge that learners will have a range of experiences and reactions. What pre-work is necessary to optimize the skills of supervisors such that they can recognize when a learner's identity characteristics might be influencing how a patient is responding to them? ● What training will be provided to ensure that supervisors do not inadvertently re-traumatize learners via their responses or failure to respond to incidents involving mistreatment? ● Are there simulated cases for all supervisors focused on appropriate ways of addressing these scenarios (informed by the needs and preferences of learners)? ● Do supervisors undergo evaluation with respect to how they respond to these scenarios? ● Is there an institutional level feedback process or evaluation of supervisors' skills from the learners' perspective? ○ If a clinical learner is exposed to biased, racist, or other harmful behaviour from patients or their family members or visitors, and the supervisor does not adequately respond or support the learner, what mechanism is in place to make the educational institution aware of the realities of the learner's experience? What mechanisms are there to alert the supervisor's direct report to the supervisor's success (or failure) to provide adequate support? ● Are supervisors capable of discussing issues related to inclusion, diversity, equity, accessibility and anti-racism (IDEAA) as they relate to learner experiences of mistreatment? ● What training is needed for supervisors who are uncomfortable with speaking to issues of racism, bias, or discrimination? How does the institution ensure that all supervisors have had some form of anti-racism training? Should they be encouraged to undergo more training to improve comfort with attending to these issues in the clinical context? ● What simulated training ought to be designed to teach learners how to respond to incidents in the moment and afterwards? Should this be mandatory preparation for learners before they begin any clinical placement?
Support	● What supports should be made available to clinical learners in the hospital? ● What processes need to be in place to ensure that if learners are exposed to blatant racist or demeaning behaviour or language, that they have avenues to cope, address, and resolve any emotional distress? ● Do learners feel that the clinical environment is respectful and supportive?	● What supports should be provided to clinical learners working in clinical environments? (Employee Assistance Programs typically offer 24 hour support only to staff members, whereas university mental health supports for learners are only available from 9am – 4pm, on weekdays). ● Which healthcare-related services are available for consultation, if any? Bioethics? Social work? Spiritual Care? An office devoted to IDEAA? ● Supervisors should be able to offer support to learners before engaging in sessions that might be conflict heavy or where they suspect that interactions might become emotionally charged. What pre-work is necessary for supervisors to offer appropriate support? ● Is the learning environment one that is supportive of addressing these concerns? Do learners feel empowered and encouraged to share when they have been exposed to discriminatory behaviour and to identify when they might need support? ● What conditions must be met for the environment to be considered safe enough for learners to share when support is needed? ● How will supervisors discern whether the learner's support needs have been met?
Reporting	● How can incidents be reported? ● Is data disaggregated to distinguish learner-involved incidents separately from those experienced by staff?	● What kinds of feedback or data are being collected? ● At what level is data currently being collected, if at all, e.g., program vs. department vs. discipline? ● What reporting tools exist for clinical learners? ● Who is responsible for monitoring these data, and identifying which programs or institutions are in need of urgent intervention or change?

CONCLUSION

Navigating clinical environments can be as difficult for healthcare workers as it is for patients. This is particularly true for those who are also evaluated for the work they do, as is the case for clinical learners. Given the hierarchy and power dynamic inherent to clinical spaces, much reflection is needed on how to best protect those who are at an increased risk of harm. This paper provided an overview of the current literature on clinical learners' experiences navigating patient bias, as well as discriminatory requests and refusals of care. We showed that the learner status, in addition to the multiple intersecting aspects of the learner's identity, affect how patients, their family members, and visitors respond or react. We outlined the differential experiences of racialized learners and those from marginalized backgrounds, noting the many sacrifices made to one's dignity and overall wellbeing. The paper highlighted that the challenges do not end with experiences of bias and discrimination; they are compounded by challenges in both responding and reporting. Despite these critical concerns, the nuances of learners' experiences and the conditions under which they work are not captured in sufficient detail in the wider literature. In response to these clear gaps, we outlined key areas for improvement in the scholarly and policy realms, noting small advancements made in our local context, in Toronto, Ontario. Future work ought to include the voices of the broad spectrum of clinical learners on what is needed before, during, and after incidents of patient bias, and ways in which responsible parties can provide meaningful support. We further call for broader bioethics engagement with this issue as well as support from healthcare leadership to move this work forward; it is only through actionable steps that we will be able to truly demonstrate our commitment to protect clinical learners.

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