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How to be a “Charming Young Lady” in Medicine

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“No matter how many times you introduce yourself as ‘The Doctor,’ patients will always refer to you as ‘That Mean Nurse.’” My preceptor shared her feelings of frustration with me as our small group rotated between rooms with standardized patients.

In our second year of medical education, we engage in biweekly “Cardinal Manifestations” cases, in which we practice typical patient encounters within the classroom setting. For each case, one student collects the history, allowing the other students to add in pertinent questions as needed. Another student performs a physical exam, and finally another student summarizes the case and provides a differential diagnosis with next steps. Each part is performed in front of the entire small group, as if every patient encounter at this stage isn’t already laden with enough pressure.

That morning, I prepared for the cases by researching common presentations for various respiratory complaints; I wrote down the key review-of-systems questions on an index card. I even ran through a full history in front of the mirror. With the seemingly endless amount of knowledge we must absorb and retain in our systems-based courses – what we refer to as our “real classes” – most students don’t find the time to prepare for these Cardinal Manifestations in advance. But I was determined.

Fast forward to the end of my history collection. My patient, a 58-year-old male, complained of “shortness of breath and a dry cough.” As I close the encounter, I sigh a bit in relief, feeling confident that I established rapport, asked all the right questions, and could give a differential diagnosis right then and there. I had asked about recent travel; I asked about military service. I had even gracefully laughed off an unexpected comment from the patient about my physique, re-directed at me when I asked about his exercise habits. My preceptor asks the rest of my group if they have any additional questions; everyone agrees I had been comprehensive. I take my seat back with the group, proud of my performance. My preceptor asks the standardized patient for his own feedback.

“That was one of the most succinct and thorough history takings I’ve ever experienced. You really did hit all the questions and more…” I feel myself beaming in my seat. The patient continues, “…but it felt like I was being interrogated. You were pleasant, but it wouldn’t kill you to smile more. It would make you come off as less harsh.” My eyes widened a bit, and I pursed my lips in a half grimace, half nervous smile. The patient points out, “Yeah, like you’re doing now! So you seem like more of a charming young lady than an FBI interrogator.” The entire class turns toward me, and I begin to see red.

My preceptor rolls her eyes; the other medical students in my group look equally as shocked as I feel, most shifting their eyes

uncomfortably. I sit through the next student’s physical exam as well as the final student’s differential diagnosis with a blank stare, replaying the comments in my head. I reassure myself, downplaying the experience. “I’ve heard about worse – real – sexism toward female medical students. Maybe I was too methodical, too efficient.” Then I shake my head, as if to get myself back into reality. “Would he have said that if I were a man?”

We are unfortunately all too familiar with the statistics: at least 70% of women perceive a gender bias within the field of medicine, and 66% report experiencing it themselves. This is in comparison to men: only 22% of which feel there is any gender bias within the field, and 10% who report experiencing it.1 But what this perhaps doesn’t account for are all the experiences, all the comments that women – and men – deem too insignificant to report. Suggestions on how to be a “charming young lady.” Or “subtle” comments regarding how much exercise it appears we engage in.

My school’s Professionalism Committee releases periodic reports providing statistics on student feedback as well as summaries of inappropriate events. We have an initiative titled, “Fostering a Culture of Change,” aiming to document all incidents and monitor progress in the safety and security of our learning environments. For the period of January 2018 to June 2019, thirteen incidents were reported; only two reported on the professionalism of a patient.2 However, it is important to note that this report also highlights the overwhelming majority of our educators who create an incredible and welcoming learning environment.

Nonetheless, the first step in creating a stronger, more unified medical community is acknowledging that the playing field is not level and that these experiences – however small – do detract from the community. We have numerous avenues to report incidents regarding our peers and educators, and we receive training from the start that encourages us to speak up so that these issues may be addressed.

So what do we lack? We lack guidance on how to respond when our patients behave inappropriately towards us, when our patients detract from our medical educations and careers. We are often caught in the crossfire of “patient-centric medicine” and personal autonomy and dignity, afraid that by standing up for ourselves, we will sacrifice our rapport. In this sense, medical schools must implement training that identifies where the line should be drawn and provides instruction regarding how to continue with the patient encounter, if indicated.

As a student liaison on a panel of course representatives, I have the opportunity to work with my peers and educators to implement such training into our curriculum. We aim to continue to move towards a culture where not only students but healthcare workers at large feel that they have a voice. A culture where we are empowered and equipped to stand up for ourselves.

References

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