

Virtual Mentor

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CLINICAL CASES

Homophobic Jokes and Patient Care

Commentary by Kate O'Hanlan, MD

Melinda is in the midst of her third-year rotations. She has been following a patient, Debbie, who is on the medicine service recovering from pneumonia and found out during her last admission that she is HIV positive. Melinda noticed that Debbie rarely has visitors, so she has spent most of her downtime visiting with her. Debbie has told Melinda much about her personal life, in particular the difficult time she had revealing her HIV status to her partner of 10 years.

One day while Melinda was writing a progress note, she overheard several residents making fun of Debbie. One resident joked that he couldn't figure out how Debbie acquired HIV, because "by the looks of it" she had been a lesbian her entire life. Another resident quipped that Debbie's haircut and clothing were "dead giveaways." A third said sarcastically, "Hey, whatever floats your boat, right?" and they all laughed. It bothered Melinda to hear the residents talking about Debbie in this way, in part because of the close relationship she had developed with her. But Melinda didn't know whether to say anything to the residents or not. What if Debbie had heard? What if anyone had heard?

Commentary

Melinda's compassion for this lonely patient and concern for professionalism made her want to defend Debbie upon hearing the other residents making fun of her, albeit in "private."

Privacy and the Workplace

Residents are certainly entitled to have private conversations between themselves, with the expectation that their confidentiality be maintained—but the work environment isn't a sufficiently private place for that expectation to be applicable. As evidenced by Melinda's overhearing them, they're not really in a private place. (They don't appear to be taking precautions to make sure Debbie doesn't hear them, either.) They are in space shared among colleagues, and the assumption by these residents that their co-workers concur with their views or find their jokes appropriate is wrong, and can harm their collegial relationships [1]. They run the risk of offending or discomfiting or alienating LGBT colleagues, those with different views, and even people who may share their opinions about Debbie but not their standards for professional behavior.

More specifically, residents are role models for students like Melinda and, as such, have a duty be particularly attentive to their conduct and the example it sets. Many

students report that everything they learned about ethics and professionalism in their first 2 years of medical school was contradicted the day they started their clinical rotations. We will have a self-defeating model of medical education, unless each person gives up the temptation to say whatever pops into his or her head and begins to substitute professional restraint.

Disdain, Discrimination, and Patient Care

Cracking jokes about patients can be a way to cope with stress, but it is unprofessional and can compromise the quality of care when the messages carry disdain for the patient. Certain kinds of humor are just not OK when they pertain to the patient-physician relationship. A patient's sexual orientation has clinical relevance and is therefore important for caregivers to know, but should be treated like other salient information gathered in the privacy of the clinical relationship, not made the subject of jokes or innuendo. The American Medical Association's "Principles of Medical Ethics" specifies that medical care be given with "compassion and respect for human dignity and rights" [2]. These residents' views evince a lack of respect for Debbie as a patient and as a person. Discrimination based on gender expression or sexual orientation has no place in medicine [3].

The residents also appear unaware that such remarks affect patient care. Research shows that such remarks can both directly and indirectly harm patient care. Cynicism toward patients with HIV on the part of resident trainees has been correlated with homophobic attitudes, an aversion to intravenous drug users, and a cynical attitude by supervising faculty [4], all of which undermine communication and trust in the patient-physician relationship.

One study found that androgynous lesbians, in particular, are more likely than those with more traditionally feminine presentation to avoid medical care out of fear of disdain by healthcare practitioners [5]—apparently for good reason. Ruth McNair writes that such discrimination can corrode the patient's view of her care and reduce her trust in the caregivers [6]. Patients are vulnerable to clinicians' judgments of them. Overhearing such comments about themselves can cause severe emotional injury to patients and destabilize clinical relationships.

Other Considerations—Medical Education

The residents' comments may indicate anxiety about the transmissibility of HIV in the clinical context due to lack of adequate preparation in their training thus far. In a 1999 survey of students at an American university-affiliated medical school, 60 percent felt unprepared to treat HIV-positive patients safely. Furthermore, the study authors found that "AIDS-phobia was significantly associated with homophobia," and, unfortunately, additional clinical education about AIDS patients and about modes of transmission did not contribute significantly to reducing those phobic beliefs; the authors suggest that such fears must be addressed separately before the students will benefit from advanced clinical learning on the subject [7]. In some cases, homophobia may be partly due to anxiety or insecurity about with one's own gender identification or "measuring up" to socially conditioned gender roles [8].

What Should Melinda Do?

Melinda must speak up—most urgently to make sure Debbie is not exposed to (further) discriminatory treatment, but also to address her own discomfort about the residents' comments. Confronting her colleagues privately is likely, as in any workplace environment, to engender embarrassment and animosity and is relatively unlikely to change their views or behavior. Since the residents appear to need further education (about professionalism and possibly about HIV-positive or LGBT patients), changes to their views and improvements in their conduct are more likely to occur if there is an impetus from above and if they are not singled out. Asking faculty for formal training for the group about ethics topics pertinent to HIV, homophobia, and the GLBT population could raise the awareness of the entire class [9].

Melinda should avoid passive-aggressive or pointed remarks (e.g., “*Some people* in the group seem to be uninformed about cultural sensitivity” or complaints such as “I don’t think you’ve prepared us for this”), but neither should she attempt to minimize conflict through self-deprecating comments. She should merely ask the attending physician if it might be possible to have a group discussion or informational session about clinically appropriate treatment for and sensitive behavior toward lesbians, HIV-positive patients, and other demographic groups represented on their unit. In such dilemmas as this, addressing the faculty and trainees, *en groupe*, while not naming names, may significantly raise the level of professionalism.

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