JOSIAH MACY JR.
FOUNDATION

Racist Patients: Taking Action on Harmful Bias and Discrimination in Clinical Learning Environments

February 25, 2021

Macy Conference

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Preview of Webinar

- Background
  - Holly J. Humphrey, MD, MACP
- Overview of ethical dilemma of biased patients, and conference recommendations
  - Pooja Chandrashekar, AB
  - Sachin H. Jain, MD, MBA
- Discussion
- Concluding comments
  - Holly J. Humphrey, MD, MACP

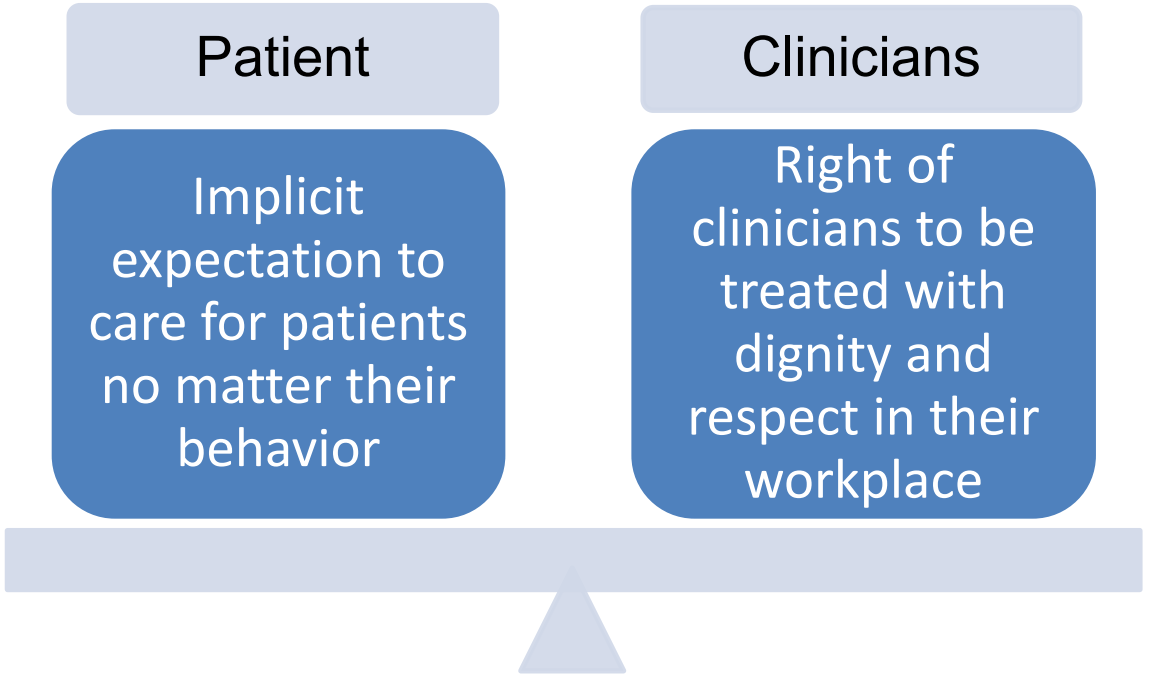
Conference Overview

- 44 leaders in health professions education, health care delivery, learners, and educational accreditors
- Four commissioned papers and three case studies
- Four recommendations based on established consensus recommendations, then refined by the planning committee and approved by all conferees
- Conference Recommendations: https://macyfoundation.org/publications/conference-summary-eliminating-bias-discrimination

Conference Vision Statement

Our nation's health professions learning environments—from classrooms to clinical sites to virtual spaces—should be diverse, equitable, and inclusive of everyone in them, no matter who they are. Every person who works, learns, or receives care in these places should feel that they belong there.

The Ethical Dilemma of the Biased Patient



How should clinicians respond when patients exhibit biased or discriminatory behavior, and how can healthcare organizations develop policies and training to mitigate the effects of these experiences?

Framework for Responding to Biased Patients

Assess	Act	After Incident

• Clinician safety and well-being
• Patient's medical condition
• Reasons for patient's request or biased behavior
	• If clinician feels unsafe, can exit encounter and transfer care
	• If patient is unstable, first treat and stabilize
	• Else, determine whether behavior is ethically justifiable
	  • If yes, accommodate
	  • If no, express discomfort and engage in negotiation and persuasion. Can transfer care.
		• Inform supervisors and administration
		• Report incident
		• Document if necessary

Addressing Patient Bias at the Institutional Level

For patients	For clinicians	For organizations
• Guidelines for patient conduct	• Education on rights and responsibilities • Training on how to respond when facing or witnessing patient bias	• Clear policies to protect clinicians • Reporting mechanisms • Systems to adjudicate blame

Culture change to normalize reporting and support clinicians

Systematic research on patient bias against clinicians

Addressing Patient Bias Against Trainees

- Set expectations
- Determine whether and how to intervene
- Debrief with trainee after incident

Recommendation I

Build an institutional culture of fairness, respect, and anti-racism by making diversity, equity, and inclusion top priorities.

Recommendation II

Develop, assess, and improve systems to mitigate harmful biases and to eliminate racism and all other forms of discrimination.

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Learning Environment

Addressing Patient Bias and Discrimination Against Clinicians of Diverse Backgrounds

Pooja Chandrashekar and Sachin H. Jain, MD, MBA

Abstract

The duty to care for all patients is central to the health professions, but what happens when clinicians encounter patients who exhibit biased or discriminatory behaviors? While significant attention has focused on addressing clinician bias toward patients, incidents of patient bias toward clinicians also occur and are difficult to navigate.

Clinicians anecdotally describe their experiences with patient bias, prejudice, and discrimination as profoundly painful and degrading. Though this phenomenon has not been rigorously studied, it is not unreasonable to postulate that the moral distress caused by patient bias may ultimately contribute to clinician burnout. Because women and minority clinicians are more likely to be targets of patient bias, this may worsen existing disparities for these groups and increase their risk for burnout. Biased behavior may also affect patient outcomes.

Although some degree of ignoring derogatory comments is necessary to maintain professionalism and workflow, clinicians also have the right to a workplace free of mistreatment and abuse. How should clinicians reconcile the expectation to always "put patients first" with their basic right to be treated with dignity and respect? And how can health care organizations develop policies and training to mitigate the effects of these experiences?

The authors discuss the ethical dilemmas associated with responding to prejudiced patients and then present a framework for clinicians to use when directly facing or witnessing biased behavior from patients. Finally, they describe strategies to address patient bias at the institutional level.

While a neurology resident at Massachusetts General Hospital and Brigham and Women's Hospital, Dr. Altaf Saadi cared for a patient who asserted that his religion was superior to her own. As she auscultated, he pointed at her headscarf and added, "Why do you wear that thing on your head anyway?"[1]

The duty to care for all patients, regardless of beliefs or circumstance, is central to the medical profession, but Dr. Saadi's experience embodies the tension that clinicians feel taking care of biased patients. How should clinicians respond when patients exhibit biased or discriminatory behavior, and how can health care organizations develop policies and training to mitigate the effects of these experiences?

Introduction

While significant attention has focused on documenting and addressing clinician bias toward patients, incidents of patient bias toward clinicians also occur and are difficult to navigate.[2] In a recent survey of 822 U.S. physicians, 59% reported having heard offensive remarks from patients about their age, gender, ethnicity, race, weight, or other personal characteristics in the past 5 years and 47% had patients request a different physician.[3] These incidents begin early in training: One study of 242 family medicine residents revealed that patients accounted for 35% of the intimidation, harassment, and discrimination experienced by trainees.[3]

Biased patient behavior can manifest in various ways in the clinical setting. In a qualitative study of 50 trainees and physicians, participants reported incidents of patient bias that ranged from explicit rejection of care and prejudiced epithets to inappropriate compliments, flirtatious comments, and belittling jokes reflecting ethnic stereotypes.[4] It is important to make the distinction between bias, prejudice, and discrimination. Individuals are often biased against others outside their social group (and sometimes against those in their social group), and prejudice refers to biased thinking, while discrimination refers to biased actions against a group of people.[5]

Clinicians anecdotally describe their experiences with patient bias, prejudice, and discrimination as profoundly painful and degrading.[6] For example, after a patient refused to see Dr. Cornelia Wieman because she was Indigenous, she recalls feeling humiliated and helpless, eventually calling for another physician because she "didn't feel like [she] had a choice."[7] Similarly, Dr. Esther Choo, an Asian American emergency room physician in Oregon, recounts her experience "cycling through disbelief, shame, and anger" after patients refused her care exclusively based on her race.[10]

Though this phenomenon has not been rigorously studied, it is not unreasonable to postulate that the moral distress caused by patient bias may ultimately contribute to clinician burnout.[8,11] This has particular implications for minority patients. Because minority clinicians are more likely to experience patient bias, this may increase their risk for burnout and lead to fewer minority clinicians in medical practice. Research suggests that racial and ethnic minority patients might achieve better outcomes when cared for by minority clinicians, so the alienation of minority clinicians by biased patients may actually worsen outcomes for minority patients.[12]

Please see the end of this article for information about the authors.

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ON BEING A DOCTOR | Annals of Internal Medicine

The Racist Patient

In my final months of residency, I was summoned to see an angry patient. Mr. R. was furious that our pharmacy did not stock his brand of insulin. He wanted to issue a complaint.

"You guys always mess up my insulin whenever I am here. I told the other doctor, and now I'm telling you. You guys just can't get it right."

"I'm sorry," I told him. "If you prefer, your family can bring your insulin from home and our nurses can administer it. Would that be an acceptable solution?"

"You *people* are so incompetent."

Uncertain of how I might best diffuse the situation, I looked uncomfortably in the direction of my patient's son, who was seated at the bedside.

"You look at me when I talk to you," Mr. R. commanded. "Don't you look at him."

"I'm sorry. Why don't I come back later?"

As I uncomfortably walked out of the room, he launched a grenade.

"Why don't you go back to India!"

On pure instinct, I responded, "Why don't you leave our [expletive] hospital?" To underscore my point, I repeated myself.

I exited the room in a cold sweat.

Much of our clinical training focuses on how to modulate our personal style to accommodate patients. We take doctoring courses that urge compassion, empathy, and cultural sensitivity. We undergo objective, structured clinical examinations that certify our interpersonal skills. Our preceptors advise us on subtle techniques and gestures to ensure that patients feel safe, secure, and confident in our care.

Yet, as I reflected on what happened that night, I realized that no one had ever raised the possibility that I might one day be hurt by a patient's words or actions. What are our obligations when we are the subject of their inhumanity, cruelty, or intolerance? When the patients whom we are treating fail to express the same decency that they demand?

The prevailing sentiment is that we are supposed to be "better" than our patients. We are supposed to be able to ignore unpleasant commentary, maintain aplomb, intellectualize difficult situations, and understand the roots of their discontent. This view was reinforced by one of my colleagues who was taking call with me that night. In his eyes, I had clearly wronged, and I might consider apologizing to the patient.

"Don't they teach us not to do that? You're better than that," he scolded when I shared my story. "You have to learn to ignore that stuff and rise above it." He expressed concern that the patient might report me to our hospital's patient relations committee and that I would be found guilty of some kind of clinical misconduct.

Another colleague was ready to fast-forward through my upset feelings and tried to make light of the fact that I, indeed, had a forthcoming trip to my ancestral homeland. "It is kind of funny, if you think of it that way."

But the reality was that I was not above reacting to Mr. R.'s contempt for me, nor did I feel like humor would help me to move on from the situation. When Mr. R. stopped seeing me as his physician or caregiver, but instead as a foreign face, I was no longer a proud physician at the hospital where I was training. Instead, I was reduced to a passive subject of a xenophobe's abuse. After years of feeling that my race was a nonissue, I was subjected to the same kind of hurtful name-calling that I faced in childhood. Even as self-loathing for not having thicker skin began to creep in, I decided that, on this occasion, my feelings would count.

The following morning, I spoke to my supervising attending physician and absolved myself of future interactions with Mr. R. He and the intern on service would sort out the patient's care without my input.

After rounding on our other patients that morning, I left the hospital with a surprising new sense that, even as I had chosen a profession that calls on me to serve, there are clear limits to that service that I am unwilling to compromise.

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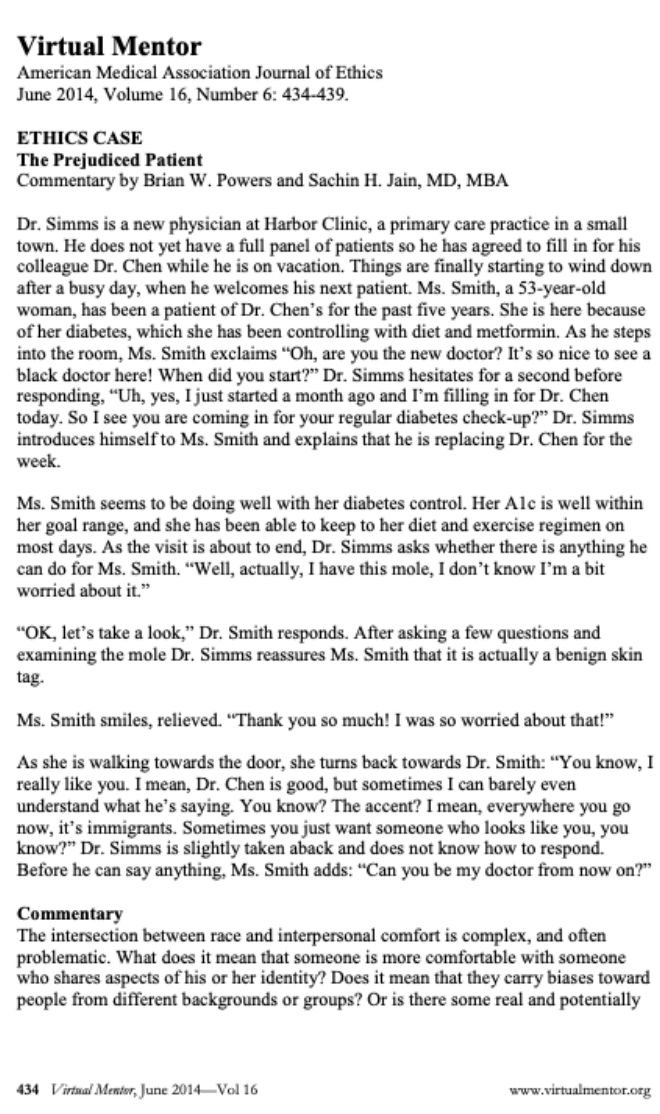

Virtual Mentor
American Medical Association Journal of Ethics
June 2014, Volume 16, Number 6: 434-439.

ETHICS CASE
The Prejudiced Patient
Commentary by Brian W. Powers and Sachin H. Jain, MD, MBA

Dr. Simms is a new physician at Harbor Clinic, a primary care practice in a small town. He does not yet have a full panel of patients so he has agreed to fill in for his colleague Dr. Chen while he is on vacation. Things are finally starting to wind down after a busy day, when he welcomes his next patient. Ms. Smith, a 53-year-old woman, has been a patient of Dr. Chen's for the past five years. She is here because of her diabetes, which she has been controlling with diet and metformin. As he steps into the room, Ms. Smith exclaims "Oh, are you the new doctor? It's so nice to see a black doctor here! When did you start?" Dr. Simms hesitates for a second before responding, "Uh, yes, I just started a month ago and I'm filling in for Dr. Chen today. So I see you are coming in for your regular diabetes check-up?" Dr. Simms introduces himself to Ms. Smith and explains that he is replacing Dr. Chen for the week.

Ms. Smith seems to be doing well with her diabetes control. Her A1c is well within her goal range, and she has been able to keep to her diet and exercise regimen on most days. As the visit is about to end, Dr. Simms asks whether there is anything he can do for Ms. Smith. "Well, actually, I have this mole, I don't know I'm a bit worried about it."

"OK, let's take a look," Dr. Smith responds. After asking a few questions and examining the mole Dr. Simms reassures Ms. Smith that it is actually a benign skin tag.

Ms. Smith smiles, relieved. "Thank you so much! I was so worried about that!"

As she is walking towards the door, she turns back towards Dr. Smith: "You know, I really like you. I mean, Dr. Chen is good, but sometimes I can barely even understand what he's saying. You know? The accent? I mean, everywhere you go now, it's immigrants. Sometimes you just want someone who looks like you, you know?" Dr. Simms is slightly taken aback and does not know how to respond. Before he can say anything, Ms. Smith adds: "Can you be my doctor from now on?"

Commentary
The intersection between race and interpersonal comfort is complex, and often problematic. What does it mean that someone is more comfortable with someone who shares aspects of his or her identity? Does it mean that they carry biases toward people from different backgrounds or groups? Or is there some real and potentially

Jain S H. (2014, June). *The Prejudiced Patient.* American Medical Association Journal of Ethics.

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Questions & Responses

Please use the Q & A function to ask questions

https://macyfoundation.org/publications/conference-summary-eliminating-bias-discrimination

Upcoming Webinars on Bias and Discrimination 2021

- March 11: LGBTQ+
- April 7: Anti-Black Racism
- Future: People with Disabilities
  Nursing in the Clinical Learning Environment

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