Annals of Internal Medicine

EDITORIAL

Addressing Patient Bias Against Health Care Workers: Time for Meaningful Change

Protests and other acts of resistance roiled every corner of the United States and much of the world in June 2020 in response to yet another Black man's death at the hands of the police. These events occurred against a backdrop of escalating and pervasive societal divisiveness, even while the world is coping with the global threat and consequences of coronavirus. Many hope this is a moment for meaningful change.

In a *New York Times* commentary, civil rights attorney Michelle Alexander poignantly noted ". . . we know these truths about black experiences, but we often pretend we don't" (1). We know that acts of disrespect and even violence occur across all sectors of society against persons because of their race. These acts are not just perpetrated by police and the criminal justice system. Through a racial lens, we know and see that persons of color are routinely denied the respect, protection, and opportunities they deserve. We also know that in addition to race and ethnicity, persons are frequently belittled, harassed, or discriminated against because of their sex, religion, disability, or difference.

No sector of society is exempt. In the domain of health care, incontrovertible evidence shows that persons of color experience health disparities, many of which are caused or exacerbated by barriers in access to quality health care as well as bias and discrimination by health care providers (2). There is also accumulating evidence that health care providers themselves are subjected to demeaning language, belittling behaviors, harassment, discrimination, and acts of violence by patients and patients' families, often because of their race or other characteristics. When experiencing or witnessing such disparaging behaviors, health care providers describe exhaustion, self-doubt, cynicism, stress, isolation, and moral distress (3–5). In one U.S. survey, half of the responding physicians and nurses reported experiencing patient bias (4). A previous survey reported that about 70% of Black physicians had experienced perceived racial or ethnic discrimination in their medical career. In both surveys, the percentage of Black providers reporting bias and discrimination was higher than for any other group (4, 6).

In their article, Paul-Emile and colleagues offer recommendations to medical centers for addressing patient bias toward health care workers (7). Their principal recommendation is for institutions to develop clear and transparent institutional patient-bias policies to guide appropriate and systematic responses by health care workers, trainees, and the institutions themselves. They recognize that there are many barriers to establishing such policies, including leadership engagement, reluctance to begin difficult and awkward conversations, tailoring policies to include clinicians in various diverse roles and service settings, and reconciling differences of opinion about the right approach to patients' bias-based reassignment requests. Furthermore, they offer specific policy details for explicitly addressing patient bias, accounting for the various roles and practice settings that providers and trainees represent, designating a team for policy implementation and staff support, designing mechanisms for reporting and tracking, and conducting training programs. One highlight of their approach is their use of an ethical framework that considers factors about the patient who is acting in a biased way, paying attention to the patient's clinical stability, decision-making capacity, and reasons for behavior. They also acknowledge that not all behavior is deliberate and not all requests are rooted in bias (8).

We applaud the authors' continued efforts to bring attention to bias and discrimination against health care providers and their current efforts to propose solutions through developing policies and procedures. Although most medical centers have antidiscrimination policies (9), and many have processes to deal with violent patients or families, few have policies that explicitly address patient bias against clinicians. Ethically informed institutional policies and procedures are essential for coordinating a consistent, system-wide response to patients or families who are using demeaning language, exhibiting discriminatory behavior, or requesting physician reassignment because of prejudice.

We believe, however, that fair and transparent policies are not enough. Institutions and clinicians themselves should also make and clearly communicate a strong ethical commitment to zero tolerance for discrimination and demeaning behavior in all directions. A commitment to zero tolerance is based on a principle of respect for all persons. Such a commitment does not necessarily preclude "accommodating" the behavior of unstable or incapacitated patients or rational requests for concordance. Yet, a commitment to zero tolerance does require brutal honesty about the extent of biased or discriminatory behavior, attention to the inherent power structures that particularly disadvantage nurses and trainees, and "upstanding" training to equip bystanders to intervene when they witness biased behaviors (10). It will also require clarity about the consequences of such behavior, accountability of institutional leaders, genuine support for those who experience or witness bias or discrimination, and assurance of a strong ethical environment in which to practice. A commitment to zero tolerance should be reflected in daily activities and relationships, provision of health care, business decisions, scholarship, teaching, and community outreach. Every health care worker, just like every patient, deserves to feel safe, respected, and supported in the medical facility in which they work, regardless of race or ethnicity. It is the right time for meaningful change.

This article was published at Annals.org on 14 July 2020.

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Disclaimer: The views expressed here are those of the authors and do not necessarily reflect policies of the National Institutes of Health or the U.S. Department of Health and Human Services.

Disclosures: Disclosures can be viewed at www.acponline.org/authors/icmje/ConflictOfInterestForms.do?msNum=M20-4542.

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Ann Intern Med. doi:10.7326/M20-4542

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