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Addressing Patient Bias Toward Health Care Workers: Recommendations for Medical Centers

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Some patients engage in behavior or use language that demeans clinicians on the basis of their social identity traits, such as race, ethnicity, sex, disability, gender presentation, and sexual orientation, and some patients even request reassignment of involved clinicians. Despite the importance and prevalence of this problem, many medical centers lack an organizational approach for addressing patient conduct. Policy development can be daunting because organizations may encounter various barriers, including reluctance of staff to have difficult conversations about race or other identity traits; uncertainty about what constitutes an appropriate response to the spectrum of demeaning behaviors and who should make this determination; what, if any, support should be offered to targeted clinicians; whether these incidents should be reported and to whom; and whether the medical center's response should differ depending on whether nurses, trainees, or other clinicians are involved. These determinations have important implications for patients' informed consent rights, clinicians' employment rights, and medical centers' obligations to protect patients' health while adhering to workplace antidiscrimination laws and institutional commitments to diversity, equality, and inclusion. This article addresses these considerations and offers guidance to organizations on devising effective policies that meet the needs of medical centers, patients, and health care workers across services and roles, including physicians, nurses, and trainees.

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A patient at a busy emergency department exclaims to his assigned resident, "I hate you, n*gg*r! Don't touch me! I hate your people!" The resident is hurt, angry, and confused and is unsure of what to do. Should she alert her supervisor? Inform hospital administrators? Commiserate with her fellow residents? Should she suffer in silence or quietly ask another resident to treat the patient? Will she be seen as unprofessional if she doesn't "handle it" herself? The resident and other members of the medical team have little guidance on how to proceed, which is not unusual.

Although most medical centers have policies on dealing with difficult patients, few have policies addressing patients' bias against their clinicians. This behavior ranges widely and includes epithets, derogatory jokes and innuendos, slurs, negative stereotyping, displays of offensive materials, inappropriate physical contact, and reassignment requests. A recent study found that 88% of 426 hospitals surveyed had no policies for dealing with patients' refusals of physicians on the basis of the physician's sociodemographic characteristics (1). Even when such policies exist, most physicians and nurses are unaware of them (2, 3). Moreover, trainees, who commonly experience patient abuse, including racial bias (4), frequently report not knowing how to respond and believe that hospital leadership would do nothing if notified (5). Nevertheless, 1 survey found that among 1186 clinicians, 47% of physicians, 34% of registered nurses, and 44% of nurse practitioners have had patients make bias-based reassignment requests (2, 6), and more general identity-based patient bias was experienced by 59% of physicians (2, 6, 7) and half of registered nurses and nurse practitioners (3, 6). Physicians most likely to experience patient bias were Black (70%) or Asian (69%) (6). Taken together, these data indicate that demeaning patient behavior toward providers is common. Yet, developing systematic responses can pose challenges for medical centers.

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With the increasing diversification of the health care workforce, the problem of patients' bias and discrimination against clinicians has garnered considerable attention (2, 7, 8–13). Nevertheless, many medical centers struggle to draft policies that appropriately guide and support affected staff. Lack of policies can result in inadequate institutional responses that threaten the therapeutic alliance necessary for the provision of quality care (14); undermine clinical standards; worsen patients' health; necessitate rearranging personnel; and impair workflow, possibly at the expense of other patients (15).

Nonaction can also impose hardship on clinicians, particularly women and persons of color, for whom explicit patient bias, such as that manifested by reassignment requests or use of derogatory epithets, compounds the detrimental effect of other, more routine patient interactions negatively affected by their race, sex, ethnicity, or other identity traits and can exact a heavy emotional toll (15–20). Consider, for example, the Black resident who is frequently mistaken for an orderly, or the Latina attending who is often asked if she's a "real" doctor. Even when these clinicians are not managing explicit patient bias, they must still contend with demeaning patient interactions triggered by their own social identities. Moreover, the expectation by some medical centers that clinicians handle encounters with biased patients without policy guidance may itself

Table 1. Relevant Laws

Statute	Purpose	Affected Group
Title VII of the Civil Rights Act of 1964	Prohibits employers from discriminating against their employees on the basis of race, color, sex, religion, and national origin	Employees
Emergency Medical Treatment and Labor Act	Creates a limited duty to provide stabilizing medical care in emergency situations to all persons in need	Medical centers
Medical informed consent	Protects patients from physical contact or treatment in nonemergency situations without appropriate disclosures and consent	Patients
42 USC §1981	Protects persons from race discrimination that denies them the benefits, privileges, terms, and conditions of a contractual relationship	Persons in a contractual relationship with a medical center (e.g., employees and independent contractors)
Title IX of the Education Amendments Act of 1972	Prohibits discrimination on the basis of sex in educational programs or activities that receive federal financial assistance	Medical students Medical residents in some jurisdictions

contribute to the creation of a hostile work environment in contravention of employment antidiscrimination laws (21).

Finally, medical centers' failure to draft appropriate policies increases their exposure to legal liability when patients make bias-based reassignment requests (21) (Table 1). This conundrum is further complicated by the need to determine the motivation for the patient's request: Is it clinically significant and reasonable, or is it based in bigotry?

Barriers to Drafting Patient Bias Policies

Medical centers face several barriers to creating policies addressing patients who display biased behavior. Managing patient bias requires medical center leadership to engage in conversations at different institutional levels about race, sex, and other types of bias in the workplace. These conversations are often difficult, creating a reluctance to begin the process. Even when these necessary discussions occur, they can be awkward and uncomfortable, in part because some clinicians and administrators may be unaware of how identity can affect workplace experiences if their own traditionally uncontested identities are rarely, if ever, called into question (22). Furthermore, the policy drafting process can present challenges, such as determining how to address patients' bias-based reassignment requests. Some team members may recommend a zero tolerance approach; others may favor allowing exceptions, such as for sex concordance; and still others may advance a case-by-case approach, which can be administratively burdensome and confusing.

Equally confounding for institutional policy drafters is determining how to address the needs of clinicians in various roles and services. The options for handling these difficult patient encounters may vary depending on the clinician's position: Seasoned clinicians may have options and need different support than junior physicians, nurses, or trainees, and emergency department and psychiatric clinicians may need specific protocols.

Identifying the appropriate administrative entities within the institution to enforce the policy is another challenge. Medical centers may also struggle with determining what information should be gathered and what should be done with these data. Will data bring unwelcome regulatory or media scrutiny? Moreover, the allocation of training time and resources for enforcement may present opportunity challenges and stretch institutional resources. In the following sections, we capture these concerns and make recommendations on best practices (Table 2) based on our combined, interdisciplinary experience and review of several medical center policies. We offer a sample policy (Appendix, available at Annals.org) that can serve as a starting point for organizations in their efforts to manage these difficult situations while supporting clinicians and respecting the needs of patients seeking care.

Recommendations for Medical Centers Responding to Biased Patients

Write a Policy That Explicitly Addresses Patient Bias

Addressing patient bias while supporting staff and respecting patients' rights begins with writing a policy because policies are necessary for establishing implementation procedures; clarifying expectations; promoting consistency; and outlining governing ethical principles, including justice and respect in health care delivery, adherence to relevant legislation, and protection of patients and health care workers. Conversely, unwritten policies can circumvent accountability processes, leading to inconsistent outcomes and an institutional culture that is at odds with organizational values. The policy drafting process should involve a multidisciplinary team with expertise in conflict resolution, medical ethics, legal advice, security services, and

Table 2. Recommendations for Medical Centers Responding to Biased Patients

Write a policy that explicitly addresses patient bias.
Establish procedures that account for clinical roles and services.
Establish trainee-specific procedures.
Make considerations for the role of bedside nurses.
Create a mechanism for reporting patient bias toward health care workers and support for persons within the organization to use it.
Designate a team to support staff and implement policies and procedures.
Ensure appropriate tracking and data collection.
Ensure adequate training for confronting bias-based patient behavior.

counseling support. Where appropriate, educational leadership should be included, along with union representation given the prevalence of workplace collective bargaining agreements.

Guidelines on patients' bias-based conduct short of reassignment may be added to existing policies on the management of patients engaged in disruptive behavior, but reassignment requests should be addressed separately because of the unique legal and clinical challenges they pose. For less extreme, yet explicitly bias-based patient behavior, such as use of racial or sexual epithets, we recommend the use of patient contracts with clear consequences for repeated violations (**Appendix**). As noted below, these should be established and monitored by a specially trained team.

When faced with bias-based reassignment requests, the patient's medical condition, decision-making capacity, and reasons for the request; the effect on the physician; and the options for responding, including accommodation, are all important considerations (23) that should be included in reassignment policies. We recommend that, if possible, bias-based reassignment requests not be honored without the targeted clinician's explicit consent. In the highly unusual scenario where the clinician does not consent and the patient does not modify their behavior, institutions should seek legal advice. This should be made clear to managers (for example, chief residents or service chiefs) who may inadvertently affirm the patient's behavior by moving the patient to a new team in an attempt to unburden the targeted clinician. On the other hand, targeted clinicians' requests for transfer of patient responsibilities should be honored, if possible. Not doing so could contravene workplace antidiscrimination laws as discussed below.

Although, in most cases, we recommend rejecting bias-based requests for clinician reassignment, policies should recognize that not all requests for reassignment are rooted in bias. Accommodation can be a reasonable option when the reassignment request stems from a psychiatric condition, such as posttraumatic stress disorder, or when the patient is not rejecting a clinician but instead is seeking an ethically or clinically appropriate form of concordance, such as language concordance for improved comprehension or sex concordance for a sensitive examination or for a survivor of sexual assault (15, 21, 23). Some minority patients may request a racially concordant physician because of mistrust of other physicians. We recommend that policies recognize patients' past experiences, including discrimination in health care settings, and allow clinician reassignment for clinically indicated concordances. This distinction may trouble those who seek symmetrical and ahistorical rules; however, important differences exist between rejections based on animus and affirming, concordance-based requests for a physician. Recognizing this distinction when adhering to our recommendations allows for conceptual clarity when considering each case.

If accommodation is impossible in concordance-based requests, then other measures to mitigate the patient's discomfort should be offered (for example, a same-sex chaperone when an opposite-sex physician does a sensitive examination). Implementing these more nuanced policies requires staff and management training and often the provision of a script, such as that used by some front-line staff in a gynecology clinic. They explain to patients that all clinicians have been trained in the sensitive and respectful treatment of women, that chaperones are available, and that although the request for a female clinician will be accommodated, it may require a longer wait time.

Establish Procedures That Account for Clinical Roles and Services

Medical centers' policies must be tailored to account for clinicians' roles because adopting universal policies is unlikely to adequately address the needs of diverse clinicians working in a range of clinical environments. The likelihood of experiencing patient bias, options for responding, legal consequences of the medical center's actions, and the clinical context in which the patient bias occurs will vary depending on the clinician's role. For example, in contrast to attending physicians, nurses and trainees, as front-line staff, are more likely to experience patient bias (6). Their increased vulnerability may be attributed to the fact that they often interact more frequently with patients, have less decision-making autonomy, and constitute a more diverse segment of the health care workforce (4, 20, 24, 25). Clinical students may fear that reporting patient bias will negatively affect their evaluations or reputation, and unlike nurses, who have clearer reporting structures through internal command chains or union representation, students may not know where to seek assistance.

Furthermore, clinicians' roles influence the legal implications of medical centers' responses to patient bias. For example, nurses, if they are medical center employees, are covered by employment laws; attending physicians may be employees or independent contractors subject to contractual arrangements; medical students are governed by education legal regimes; and residents may be covered by both employment and education antidiscrimination laws. Therefore, although medical centers must screen and stabilize all those who present with emergency medical conditions in accordance with the Emergency Medical Treatment and Labor Act (26), if they acquiesce to a patient's demands to reassign a nurse on the basis of race, sex, or ethnicity, they may violate Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination. A request to reassign an independent contractor physician may not violate Title VII or state and local workplace antidiscrimination laws but may contravene section 1981 of the Civil Rights Act of 1866 (27), which protects persons from race discrimination in contractual relationships. Meanwhile, medical residents have been found by some courts to be both students and employees (28–30), and thus are able to bring claims for sex discrimination under employment (22) and education (31) antidiscrimination laws. This avails residents of the compensatory and punitive damages available under Title VII, along with termina-

tion of their program's federal funding under Title IX of the Education Amendments Act of 1972 (31).

Finally, procedures may also need to differ on the basis of the clinical services and settings involved, such as psychiatric wards or emergency departments, where the patient's capacity may be in question or where a patient demanding reassignment may lack the clinical stability necessary for transfer to another facility (23). Under these types of circumstances, patients' expressions of bias may require supplemental protocols and highly tailored, clinically appropriate solutions (23).

Develop Trainee-Specific Procedures

Students may require protocols that deliver more immediate guidance. We recommend that students targeted by biased patients be exempted from providing further care to the patient. Requiring students to care for biased patients before they have developed the clinical experience to do so may be detrimental to their learning and professional development. Students wishing to continue caring for these patients with appropriate supervisory support could "opt-in" (that is, make an explicit request to continue participating in the patient's care) if explicit consent to student care is not required under relevant state law. If a patient's withdrawal of consent to student care is rooted in bias toward a particular student, no other students should be involved in the care of the patient. With respect to residents, we recommend an opt-out mechanism, as is our recommendation for attending physicians, where patient reassignment occurs only at the resident's request or with explicit permission.

Both students and residents should report these incidents to supervisors, who should acknowledge the patients' misconduct and determine whether and how the trainee wishes to proceed with the patient (32). Clinical supervisors should coach trainees in how to respond, model appropriate behavior, set limits, inform patients that discriminatory behavior is impermissible, and monitor these situations and their toll on trainees.

Consider the Needs of Nurses

Nurses provide most face-to-face care to patients, often during 12-hour shifts. This can be profoundly difficult when patients are exhibiting explicit bias. Nevertheless, employment laws may be violated if nurses are reassigned on the basis of bias without their consent. We suggest that protocols for nurses, as for physicians, allow enough flexibility to capture the nuances of individual cases; ensure that targeted nurses have autonomy and support to decide whether to be reassigned; allow nurses to request a behavioral contract consultation from colleagues in the patient experience office, patient grievance office, or psychiatry department without a physician's approval; and have clear thresholds for assisting patients with discharge or transfer when behavioral contracts are violated. Policies for nursing and other health professional students should mirror those of medical students.

Create Support for Reporting

To effectively address patient bias, incidents must be reported. Reporting informs the creation of best practices and appropriate supports for staff while allowing for more accurate interpretation of patient satisfaction scores (a clinician's negative evaluation resulting from responding to a biased patient can be discounted if the event is reported). In addition, written policies are only effective in a climate that supports reporting because even strong policies cannot produce substantial change if clinicians feel unsafe reporting or fear that their claims will not be taken seriously or might harm their careers (33–36). These are particular concerns for trainees who may be reluctant to report mistreatment by patients (32).

Consequently, institutions must create mechanisms for reporting while fostering a culture that supports it. This endeavor, which may be undertaken by existing committees, should involve adopting standardized policies and procedures; allocating resources to execute them, including designated positions with ongoing financial support; assigning staff to handle reporting; and having clear reporting expectations, safe reporting mechanisms (including the collection and analysis of the information), and a transparent means of evaluating the efficacy of these efforts. Staff should have a clear sense of what to expect when they make a report and how the data will be used.

Designate a Team to Support Staff and Implement Procedures

Lasting culture change requires the designation of personnel to implement policies and procedures, support affected staff, and facilitate reporting. Although roles differ within medical centers, the chief experience officer, director of wellness, director for organizational diversity, or director of human relations could assume these responsibilities, with input from the multidisciplinary team assigned to draft the approved policy and other key stakeholders. Identifying staff consultants to help with issues such as deescalating encounters involving recalcitrant patients, assisting in conflict resolution, and offering legal advice will ensure that institutionally vetted procedures are followed. These consultants should be trained in the substantive issues and in the processes of effective "consult team" engagement. Drafting and enforcing patient agreements to establish limits and expectations for patient conduct, training staff on responding to biased behavior, and providing group or individual counselling for affected staff when needed are essential to successful implementation.

Although in emergency situations staff must first screen and stabilize the patient (23), use of this consult team resource would be helpful, particularly to clinicians, who often lack the expertise or time to deal effectively with these situations. In addition, we recommend permitting floor and charge nurses to initiate consultations. This affords nurses more guidance and support, empowering them to attend to their own and their patients' needs.

Ensure Appropriate Tracking and Data Collection

As with other workplace initiatives, organizational responses should be data driven. Along with workplace milieu surveys, medical centers should track and collect data on encounters with biased patients, including how often and where they occur, the effect on staff, the support they receive, and the institution's response (32). Tracking these incidents for trainees is important to en-

sure the quality of the clinical learning environments. Surveys on learning environment should include questions about witnessing and experiencing patient bias and on trainee and institutional responses. Survey data should be shared with medical center leadership and educators. Data collected from staff and students can be used to gain a systematic understanding of the problem, devise best practices, and offer an appropriate response. Medical center entities best able to respond include workplace violence and safety committees, staff experience and work milieu task forces, or performance improvement and patient safety committees.

Ensure Adequate Training for Confronting Biased Patient Behavior

At some point in their careers, all team members will likely experience or witness patients' discriminatory behavior. Given that complete prevention is impossible, awareness and preparation are crucial. Clinicians must learn how to manage these patient encounters as both targets and bystanders. Without training, clinician responses may vary widely (5, 20) and may not meet patients' clinical needs or reduce the emotional toll on targeted clinicians. For example, one physician may feel responsible for safeguarding those who are more junior or vulnerable, whereas another may believe that responding to a patient's insult is the mark of a less competent physician (37). Trainees may be reluctant to defend a targeted team member who is higher in the medical hierarchy for fear of undermining the person's authority. Training can dispel the common belief that tolerating such behavior is part of the job and instill the skills necessary to handle these incidents appropriately (37). Although we believe that dedicated training workshops are most effective, training on how to deal with biased patients should, at a minimum, be integrated into existing training on diversity, equity, and inclusion; bias-related conflict resolution; or relationship-centered communication frameworks. Ensuring that attending physicians can teach trainees how to respond to biased patients will likely require faculty development.

Research on the experience of trainees and physicians underscores the need to include debriefing and team meetings as key components to encounters with biased patients (37). Resources should be allocated to support debriefing because encounters with biased patients can adversely affect all team members, including bystanders. A discussion by the entire team can raise awareness, allow for discussion of ways to manage these situations, foster allyship, and produce more inclusive work environments. Participating in a team meeting can also help prevent those who have been targeted from internalizing patient bias or feeling that tolerating discrimination is an expectation of the profession (37).

CONCLUSION

This appeal for medical centers to adopt policies addressing patients' biased conduct toward clinicians is yet another call for action among many that medical centers face, and the addition of new responsibilities may seem like a bridge too far to stretched health systems and clinicians. However, quiet acceptance of biased patient behavior is not a defensible norm for medical centers. The need for policies is compelling because they may not only help medical centers avoid unnecessary legal liability but may also contribute to the creation of a more effective and inclusive workplace. Moreover, these policies will likely address the substantial but difficult-to-document costs of burnout, as reflected in the high costs of recruitment and retention, the potential adverse effects on students' and trainees' career decisions, and the grave danger of the health care profession losing some of those it needs most. Ultimately, patients will benefit as well.

Biased behavior can be found in many professional contexts, and medicine is no exception. Although physicians' bias and discrimination against patients is a much more common and enduring concern (38–44), patients' bias toward clinicians remains a substantial impediment to creating a more equitable medical culture. Therefore, the medical profession must expand awareness at all levels of practice and training on how to talk openly, honestly, and productively about race, sex, and ethnicity bias and discrimination on the part of both patients and physicians. Until this happens, and as long as clinicians, particularly women and persons of color, continue to bear the brunt of patients' identity-based biases, medical centers should enact policies and procedures to protect their patients, clinicians, and trainees.

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Appendix: Sample Policy for Appropriate Management of Patients' Biased Conduct or Reassignment Requests

I. Purpose

The purpose of this policy is to guide an appropriate response to patients' or their surrogates' biased conduct toward staff (clinicians, nurses, trainees, and ancillary staff), including patients' reassignment requests based on their assigned staff members' social identity characteristics, such as race, sex, and ethnicity, and to support affected staff while encouraging incident reporting and tracking, data collection and review, and education and training. This policy is complementary to Administrative Policy 16.04 Title: Patient Rights and Responsibilities, which sets an expectation that patients will be considerate of the rights of other patients and this organization's workforce. Similarly, this policy aligns with this organization's ongoing diversity, equity, and inclusion activities and workplace violence and safety initiatives, which are intended to heighten awareness of bias on our campus and reduce its presence and effect on our workplace.

II. Statement of Policy

This organization prohibits discrimination on the basis of race, color, national origin, ancestry, age, disability, medical condition, and, where applicable, marital status, familial status, parental status, religion, sexual orientation, gender identity, gender expression, genetic information, political beliefs, and educational background or economic status. Consistent with this commitment, this organization is dedicated to protecting patient autonomy and the rights of all staff to a safe and productive work and learning environment that is free from bias, discrimination, harassment, and abuse based on their social identity characteristics, such as race, sex, and ethnicity. To meet these obligations, this policy sets forth a process to guide all staff in managing such behavior by patients, including patients' requests for reassignment based on the social identity characteristics of staff involved in their care. The policy includes the following 10 elements:

1. Assess the patient's medical condition
2. Assess the patient's or surrogate's decision-making capacity
3. Establish expectations for the provision of care
4. Options for responding to reassignment requests
   a. Determine the reasons for reassignment request
   b. No compelled accommodation of patient reassignment requests
   c. Accommodation of reassignment requests
   d. Reassignment requests involving trainees
5. Options for responding to patients' biased conduct or reassignment requests deemed unethical or inappropriate
   a. Patient care agreements
   b. When agreement not followed by inpatients
   c. When agreement not followed by outpatients
6. Support for affected staff
7. Reporting
   a. Manager or supervisor responsibility
   b. Staff reporting procedures and guidelines
   c. Unusual occurrence report
8. Tracking and data collection
9. Data review
10. Education and training

III. Definitions

1. Social identity characteristics: race, ethnicity, color, religion, sex, gender identity or expression, sexual orientation, national origin (ancestry), disability, age, language, citizenship, or any other status protected by applicable federal, state, or local law.

2. Clinical staff: medical personnel involved in a patient's care, including but not limited to clinicians, nurses, and trainees (students and residents).

3. Ancillary staff: nonmedical personnel, including but not limited to porters, food service workers, and facilities engineers.

4. Staff: includes both clinical and ancillary staff.

5. Patients' biased conduct: inappropriate behavior, comments, jokes, and innuendo; epithets, slurs, or negative stereotyping, whether spoken or written; displays of offensive materials; unwelcome physical contact based on staff members' social identity characteristics.

IV. Procedure

The urgent medical needs of each patient must guide staff and medical center decision making in

cases that involve patients' biased conduct or requests for reassignment based on the staff members' social identity characteristics. When these circumstances arise, the affected staff or member of the clinic management team should intervene immediately to evaluate the situation. The following processes should be followed in all instances:

1. Assess the Patient's Medical Condition

Appropriate clinical staff should evaluate the patient to determine the patient's clinical stability. If the patient is unstable, they must receive stabilizing treatment. If an unstable patient demands reassignment on the basis of the assigned clinical staff's social identity, other clinical staff may be permitted to conduct the patient's initial evaluation. Under such circumstances, the patient must be informed that the assigned clinical staff remain responsible for the patient's treatment and that having other clinical staff perform the physical evaluation is done only under special circumstances, such as when a patient's medical condition requires a delay in the resolution to such a request.

2. Assess Patient's or Surrogate's Decision-Making Capacity

If the patient is stable, their capacity must be assessed. If the patient lacks capacity, staffing and institutional decision making regarding the patient's biased conduct or reassignment request will be made on a case-by-case basis. If the patient has capacity, the following procedures 3 to 6 should be followed in all instances.

3. Establish Expectations for the Provision of Care

Affected staff or member of the clinic management team must attempt to set mutually acceptable expectations for the provision of care. If comfortable and practical, involved staff should identify the biased conduct to the offender and request that it stop. In so doing, staff may discuss the behavior with the offending patient and clarify why the specific behavior is problematic. The patient and his or her surrogate, family members, representatives, and visitors must be informed that biased conduct will not be tolerated.

If it is not comfortable or practical for involved staff to confront the offending patient directly, or if the staff member has done so and the biased conduct continues, staff should promptly report this to their immediate manager or supervisor or member of the management team as outlined herein (see IV.7. Reporting).

4. Options for Responding to Reassignment Requests

a. *Determine the Reasons for the Reassignment Request*. If the patient's biased conduct involves a reassignment request, the reason(s) for the request must be determined. Examples of clinically and ethically appropriate reasons for reassignment include requests for certain types of concordance (for example, language, religious, and sex concordance under certain circumstances [for example, for a sensitive examination] and requests that are manifestations of clinically significant conditions [for example, posttraumatic stress disorder]). If the reasons for the patient's request are not clinically or ethically justified, then a decision should be made on a case-by-case basis with consideration of the patient's autonomy, antidiscrimination laws, and the medical center's duty to treat as outlined herein (see IV.5. Options for Responding to Patients' Biased Conduct and Reassignment Requests Deemed Unethical or Inappropriate).

b. *No Compelled Accommodation of Patient Reassignment Requests*. The medical center will not force any clinical staff to treat or refrain from providing treatment to a patient who has requested reassignment on the basis of the clinical staff member's social identity characteristics.

c. *Accommodation of Reassignment Requests*. If affected clinical staff wish to accommodate the patient's reassignment request, the decision is permissible if

i. other appropriate medical personnel are available;

ii. the clinical staff involved are comfortable with and agree to the decision;

iii. accommodation can be made within the practical constraints of providing appropriate care for other patients;

iv. procedures (as outlined below) are in place to provide institutional support and guidance to the staff involved;

v. no clinical staff are compelled by this organization to accommodate a patient's bias-based reassignment request without explicit consent; and

vi. the decision does not compromise the provision of quality medical care.

d. *Reassignment Requests Involving Trainees*. When bias-based patient conduct or reassignment requests involve trainees, the following should be done:

i. Students should be exempted from further care of the patient unless they request to continue participating in the patient's care; continued care under such circumstances is permitted under relevant state law, and the attending physician and the clerkship director or nursing supervisors should be notified.

ii. Residents should continue treating the patient unless they request or consent to reassignment; and the residency site director is notified of the incident.

iii. In all cases, supervisors must determine how the trainee wishes to proceed, including assessing whether the trainee wishes to handle the situation without direct supervisor intervention, and inform the patient or surrogate that all clinicians and staff are properly trained, credentialed, and supervised. To provide the highest-quality care to all patients, the organization does not accommodate bias-based reassignment requests. The organization remains available to hear patients' con-

cerns about care and will work tirelessly to provide patients with care of the highest quality.

5. Options for Responding to Patients' Biased Conduct or Reassignment Requests Deemed Unethical or Inappropriate

Our mission at this organization includes caring for patients whose challenges may include behavioral issues that make it difficult, if not impossible, for them to receive care elsewhere. Even if a patient is transferred to another clinic or hospital to ensure a safe and respectful work environment for all staff, any patient presenting emergent concerns at the organization will be evaluated in the medical or psychiatric emergency department or urgent care department. Nevertheless, if a patient engages in biased conduct or requests reassignment for reasons deemed unethical or inappropriate, or is unable to follow patient agreements, the following protocol should be followed to the extent practicable.

a. *Patient Care Agreements.* If face-to-face meetings with the patient to establish clear understandings of respectful interactions are unsuccessful in stopping repeated biased or disruptive behavior, development of a patient care agreement is appropriate to establish shared boundaries. These agreements should be developed in appropriate cases to facilitate behavioral changes and signed by patient and clinical managers.

The patient care agreement should include:

i. a statement that the patient will abide by the patient care agreement terms, including the consequences of nonadherence (for example, required transfer of care to a different site);

ii. identification and description of the specific conduct that has led to the need for a patient care agreement;

iii. a statement of the protocol to be followed for continuation of care or transfer of care to a site outside the organization that accepts responsibility for care if this is determined to be the best course of action;

iv. a space for the patient's written suggestions of ways that he or she can avoid engaging in future biased conduct;

v. a space for the patient to suggest ways for the organization to improve its methods of avoiding or addressing conflicts between patients and staff in ways that are respectful to both parties, and consistent with the organization's mission;

vi. affirmation that patients with urgent or emergent medical or psychiatric needs may seek services at urgent care or the emergency department;

vii. a statement that the patient agrees with the patient care agreement's terms and conditions for care, with a space for the signatures of the patient, clinical manager, and relevant physician or other designated staff member involved in the care, and the date of signing; and

viii. a signature line for the patients who do not agree with the patient care agreement's terms and conditions for care to attest to having reviewed the protocols and available options with staff.

The patient care agreement may include:

i. an expectation that the patient will communicate only with a designated clinical staff member to avoid miscommunication among staff and patients regarding complaints or problems; and

ii. a treatment plan that specifies referral to behavioral health, case management, substance use treatment, or other relevant services as is appropriate.

b. *If the Patient Care Agreement Is Not Followed by Inpatients.* Inpatients or their surrogates may be informed by clinical staff, with support of the medical team, of their right to seek care elsewhere, and their responsibility not to engage in biased conduct. If the patient or surrogate, under circumstances that are nonemergent, continues to engage in biased conduct, then discharge as outlined herein should be considered and the behavioral response team, ethics committee, and risk management team should be consulted. If the patient's behavior causes team members to feel unsafe, campus security should be involved to manage the situation safely. Reporting requirements as outlined herein should also be followed (see IV.7. Reporting).

c. *If the Patient Care Agreement Is Not Followed by Outpatients.* Outpatients or their surrogates may be informed of their right to seek treatment elsewhere if they engage in biased conduct. Depending on the severity of the behavior or recurrent inability to follow an established patient care agreement (see IV.5.a. Patient Care Agreements) the patient may be transferred to an outside clinic following the processes of IV.5.a. herein, and other relevant standing policies at this organization.

6. Support for Affected Staff

Support should be offered to all involved staff when they experience patients' biased conduct. Appropriate support may include debriefing with affected staff by a clearly designated staff member and the convening of a meeting of the staff involved in the patient's care to discuss the incident, evaluate how the team responded, and discuss how best to address future patient bias incidents. Individual and team counselling or support may be provided by the critical incidence response team in conjunction with the employee assistance program and the leadership in the specific unit.

7. Reporting

Persons who experience or observe patients' biased conduct must be permitted to report their concerns without fear of retaliation. Staff members may submit concerns in writing, in person, by e-mail, or by telephone, as described below. No person will be adversely affected in their employment as a result of reporting a good-faith complaint of patient bias or for participating in any investigation. Investigations will be

done as efficiently as possible and every effort will be made to ensure that complaints are resolved promptly and effectively.

a. *Manager or Supervisor Responsibility.* Managers and supervisors have an affirmative duty under this policy to protect staff from patients' biased conduct and to promptly report to their supervisor(s) any such incidents that they witnessed or become aware of within their own department or another department, regardless of whether the alleged recipient of such conduct makes a formal complaint.

b. *Staff Reporting Procedures and Guidelines.* This organization encourages staff to report any perceived incident of patients' biased conduct, regardless of the offending patient's identity or position. Anyone who believes that he or she is a victim of such conduct should do the following:

i. If comfortable and practical, involved staff should identify the offensive behavior to the offender and request that it stop.

ii. If it is not comfortable or practical for involved staff to confront the offending patient directly or if the staff member has done so and the biased conduct continues, involved staff should promptly report such conduct to their immediate manager or supervisor or member of the clinic management team.

c. *Trainee Reporting.* Reporting structures should ensure that students know where to seek assistance, and should account for the potential concern among trainees that reporting patient bias may negatively affect their evaluations or reputation.

d. *Incident Report.* To facilitate the tracking of incidents, any person involved in the matter is encouraged to submit an unusual occurrence report.

8. Tracking and Data Collection

Patient bias incidents and reassignment requests will be tracked and documented on standardized forms and reported to the workplace safety and violence committee. This collected data should include, but is not limited to, the department where the incident occurred, how often these incidents occur, the medical center's response, the ultimate resolution, the effect on staff, how affected staff are supported, and how affected staff feel about the encounter and the medical center's response. Tracking and data collection systems for trainees should be overseen by educational supervisors and reported both to school and hospital administrations.

9. Data Review

The workplace safety and violence committee will direct the collected information to the appropriate standing committees overseeing relevant matters, including the staff well-being committee, the dean's office, and affiliated medical training institutions. These committees shall review all submitted reports on a regular basis, update medical center policies as necessary, and make revised policies available to all staff in a timely manner. Their annual reports to the hospital-wide performance improvement and patient safety committee, and the medical executive committee should include updates on these matters.

10. Education and Training

Bias-based demeaning behavior and reassignment requests can have a demoralizing effect on staff. Advance knowledge and training about this organization's policies and procedures will better prepare staff to determine the appropriate course of action in these challenging situations. Accordingly, this policy should be included in regular staff and trainee education programs. These trainings should be designed to enhance staff knowledge and skills for identifying discriminatory behavior with the intent of reducing the common tendency to overlook these affronts as part of the job; increase staff awareness of available supports; enable staff to effectively manage patient bias interactions; and understand the need and processes for reporting incidents.

V. Cross References

Administrative Policy 16.03 Patient/Visitor Grievance Policy

Administrative Policy 16.04 Patient Rights and Responsibilities

Administrative Policy 20.09 Primary Care Clinics: Transfer of Care of Disruptive or Threatening Patients