Patient bias and discrimination towards providers

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Abstract Patients and their families come with prejudices and biases that include how they view providers. Providers, in turn, must sometimes care for people whose beliefs, actions or words they may find objectionable. Discrimination against health-care providers, including refusing care from a provider and requesting another based on race, ethnicity, religion, gender, age or sexual orientation, is a complex issue for all involved, especially leadership. 'The needs of the patient come first' has historically meant respecting and yielding to patient requests and caring for everyone with professionalism, regardless of one's personal opinions. Much more work is needed to effect meaningful change so that all may benefit from broad culture-changing responses, guidelines and formal anti-discrimination policy statements. Patient satisfaction and the needs of the patient have always been paramount, but providers should not have to tolerate a work environment fraught with racism, hostility, verbal abuse and threats. While the emphasis on patient-centred care remains steadfast, it is time to expand the conversation to include the importance of provider satisfaction and well-being: the 'Quadruple Aim'.

KEYWORDS: patient, discrimination, bias, health care, misconduct

A scene in the 1968 Steve McQueen film *Bullitt* depicts a witness who has been shot and is to be operated on by a young black surgeon. The district attorney (DA), played by Robert Vaughn, demands that he be replaced. The nurse defends the young surgeon, affirming that he is one of their best. The DA responds that he is young and inexperienced. Back in the room, the two white leads exchange a meaningful glance of mutual recognition and deep understanding, leaving no doubt that this was racism and not a concern over 'lack of experience'.

While racism may have been considered justifiable by many in a 1968 film, racism or other forms of discrimination should not be considered tolerable in the modern 2018 healthcare setting. And yet, real-life modern-day examples exist throughout the world.

Take, for example:

Middle Eastern heritage trauma surgeon rejected by patient.
White parents request child not be cared for by black physician.
Patient to NY-born Iranian doctor: 'You look like someone who's gonna blow the place up.'

Michigan nurse sued hospital for granting dad's request for 'no African American nurses'.
Jewish Holocaust survivor requests not to have a German doctor.
White man in heart failure to black emergency room doctor: 'I won't be seen by a n%##!@!'*

Patients and their families, like anyone else, have prejudices and biases that include how they view their caregivers. And, in turn, providers often care for people whose beliefs, actions or words they find objectionable or cannot relate to. Discrimination against health-care providers may include refusing care from a provider and requesting another based on race, ethnicity, religion, gender, age or sexual orientation, and not always in a respectful manner. And yet, with patient-centred care driving their missions, administrators and providers have historically respected, and yielded to, many patient preferences. Physicians commit to an oath to care for all patients with equal professionalism, regardless of their opinions of them, which are put aside. This leaves no option for rejecting patients on the basis of their values. Patients have the right to choose health-care providers, and they make that choice for myriad reasons, based on whatever criteria they personally value aside from the standard objective qualifications. These may also include intangibles such as personality, bedside manner and perceived communication skills, among many others. The healing professions have historically had a very high threshold to deny a patient preference. Is a former culture of being accommodating to patient requests slowly turning to one of resistance against discrimination? Do patients have a right to discriminatory requests?

The well-established ethical and legal principles of patient autonomy and informed consent dictate that patients may guide their own care. These help protect competent patients from unwanted or poorly understood care, with the option to refuse care. Emergency Department patients are protected by the Emergency Medical Treatment and Active Labor Act (EMTALA), a federal law enacted in 1986, which requires hospitals to stabilise patients or transfer them to a facility able to provide appropriate treatment.[1] This unfunded mandate applies to anyone coming to an emergency department, regardless of their insurance status or ability to pay. Another important legal consideration is Title VII of the Civil Rights Act of 1964, from the Equal Employment Opportunity Commission. This states that a provider's workplace must be free of discrimination based on race, religion, sex or national origin.[2] Given this, organisations making staffing decisions or compelling employees to accommodate a patient request for reassignment based on these criteria have been successfully sued.[3]

Do providers have to honour discriminatory requests? Beyond the ethical and legal considerations, further guidance is needed to optimally respond to a patient rejecting a physician based on bias and presenting providers with personal, ethical, social, legal, moral and clinical care conflicts. Five primary factors[4] should be considered:

a. Patient condition. In a medical emergency, stabilise the patient.
b. Decision-making capacity. Cognitive impairment or reversible disorders may affect reassignment requests based on bigotry.
c. Options for responding to the request. Respectfully persuade the patient to accept the offered treatment. If available, physicians may decide among themselves to reassign as long as the care of other patients is not affected. Or a patient may allow current care until another provider is available.
d. Reason for request. Ask why. Understand the reason, the motive behind the request and the discriminatory behaviour. Confirm your initial assumptions. How critical is the request to the patient?

Rejection that is motivated by bigotry alone does not deserve accommodation. Rarely, physician refusal may seem reasonable, such as prior personal traumatic experience with a group. Consider, for example, the earlier introductory example of the Holocaust survivor, or another similar unique 'one-off' type circumstance. While physicians may not 'have to' honour these requests, it may behove them to consider these rare exceptions. Without succumbing to potential subjectivity and variations in interpretation, they ought to try to differentiate fears based on historical mistrust from malicious discrimination whenever possible.[5] Requests for ethnically or racially concordant physicians may be considered appropriate for religious, cultural or language considerations. Research has shown that the highest accommodation of discriminatory preferences is made for non-white and Muslim female patients. Female and non-white physicians are those found to be more likely to accommodate such patients.[6] Minority groups may request concordant physicians based on prior discrimination or negative experiences resulting in mistrust. These should be distinguished from bigotry. Institutions commonly facilitate linguistic and ethnic concordance for patients. They acquiesce if these requests seem reasonable, because patients are more comfortable, trusting, satisfied and likely to follow treatment plans if cared for by a concordant physician.[7]

e. How will the patient's preference and potential decisions affect the staff? Responses also require (a) developing rapport with the patient and family, (b) depersonalising the event and (c) ensuring the safety of all those involved.[8]

Providers and institutions are determining that it is time for a change; that it is time to respond to patient misconduct and discrimination. This includes proactively addressing potential patient discriminatory requests. Documenting events of discriminatory behaviour by patients will help guide and, if necessary, help justify revising a patient rights and responsibilities policy to cover occasions on which patients demonstrate discriminatory behaviour and prejudice towards staff. Do not wait until an untoward event occurs to consider this change. Many institutions have adopted language into formal policy and procedure statements clearly conveying that they will not honour patient requests for specific providers based on race, ethnicity, religion, or sexual orientation or gender. Many are qualifying this by stating that requests for provider or medical staff changes based on gender may occasionally be considered on a case-by-case basis in extenuating circumstances. It has always been universally held that healthcare institutions and providers have responsibilities to their patients. More and more, the converse is also being recognised — that patients also have responsibilities in this complex interaction. While patients are afforded many rights (including access to quality care regardless of their background, with respect and dignity), they also have responsibilities. Disrespect of other patients or staff must not be tolerated. Documents such as these policy statements are in the purview of anticipated regulatory and accreditation managers as they discuss rights and responsibilities required by the Department of Health, Centers for Medicare and Medicaid Services, and Joint Commission. Diversity thought leaders will also have a significant contribution to the patient responsibility component designed to respect the well-being of the staff.

People consider health-care professionals and institutions to be moral agents that cannot or should not remain neutral with regard to values. While these are all 'teaching opportunities', is it physicians' role to change society's divisive attitudes, defend societal values and teach lessons

on race relations? Others might argue that they should respect people's right to choose their own doctors, for their own reasons. Additional rebuttals may be that getting the best possible health care is more important than 'political correctness' and that patients do not need even more stress and anxiety. Undue provider–patient tensions may compromise care.

A formal policy statement discounts these arguments. Is it really possible to make a standard blanket rule for every patient request? Are some patient preferences more legitimate, some requests more justifiable, than others (eg cultural sensitivity or modesty issues with respect to gender)? Is there a spectrum, with the least justifiable predicated on prejudicial attitudes about ethnicity and race? These societal determinants call for debate and ethical judgment.[9]

Most institutions have no policies, guidelines or tools outlining steps to address, and respond to, discrimination. That clearly needs to be changed. The change process must begin with training, with meaningful dialogue on misconduct towards health-care providers due to patient-held biases that are offensive and discriminatory. Preparing strategies, including simulations, teaching modules and dedicated protocols, will equip and help train medical professionals to respond constructively to scenarios of discriminatory patient encounters.

An increasingly diverse country must tackle issues related to race, prejudice and discrimination. These will increase as the physician population becomes more diverse. It is highly likely that in a pluralistic society, the values, lifestyles, choices and words of some will offend others. Physicians must balance the best interest of the patient with aversions towards that patient. Unacceptable patient conduct requires supporting all staff and helping them handle these complex circumstances, which are fraught with tension, anger, confusion, frustration, resentment and assumptions. Physicians should try to dictate their actions around sound ethical and legal principles rather than subjective moral and emotional reactions. It may be that sometimes it is simply necessary to inform patients that if they reject their provider, they have the right to seek care elsewhere.

Many institutions have already paved the way towards better understanding of, and the fight against, patient bias and discrimination towards providers. Much more work is, however, needed to effect meaningful change and provide ultimate effectiveness created by these changes. By all accounts, everyone will benefit from broad anti-discrimination policies. As more providers come forward with their experiences, more institutions will work even harder to help address discrimination against providers by devising their own new culture-changing responses, guidelines and formal policy statements. Patient satisfaction and the needs of the patient have always been paramount, but providers should not have to tolerate work environments fraught with discrimination, racism, hostility, verbal abuse and threats.

The Institute for Healthcare Improvement instituted a framework describing the optimisation of health system performance, stating that three mutually reinforcing dimensions must be simultaneously pursued. They promoted the 'triple aim' construct of (a) improving the patient care experience (quality and satisfaction), (b) improving population health and (c) reducing costs.[10,11] A 'quadruple aim' is now described, where the fourth component is provider well-being. An important component of this is minimising the effect of patient bias and discrimination against providers.

Enhancing quality and outcomes for patients and for organisations has been an intense recent focus. What must now be addressed with the same degree of effort is improving the experience of providing care, increased employee satisfaction, increased employee engagement and reduced provider burnout.[12] The emphasis on patient-centred care ('the needs of the patient come first')

remains steadfast, but it is clearly time to expand the conversation and equilibrate the emphasis on the importance of contributing to provider satisfaction and provider well-being.

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