

Virtual Mentor

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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

valuable connection that we feel with those with whom we share these commonalities?

The case example powerfully raises these questions—by turning on its head the more commonly raised scenario of a white patient requesting a white physician or expressing negative thoughts about a physician who is not white [1]. In the prompt, an African American patient, Ms. Smith, expresses greater comfort with an African American physician, Dr. Simms, than with Dr. Chen, her longstanding Asian primary care doctor.

Race and Patient Preferences: Plenty of Evidence, Fewer Answers

Soliciting and honoring patient preferences has become an increasing focus of our health care system—a core tenet of patient-centered care [2]. Ms. Smith states clearly her preference to be seen by an African American. She is not alone. When allowed to choose their physicians, patients, especially African Americans, tend to choose those of the same race or ethnicity [3-5].

This choice has an important impact on the health care experience and the delivery of care. Visits between race-concordant doctors and patients have been found to be longer and to correlate with greater patient satisfaction and physician engagement [3, 4, 6]. Many African American and Hispanic patients feel that race concordance positively influences a physician's empathy [7]. Furthermore, patients with race-concordant physicians, especially African Americans, are more likely to use needed services, including preventive care, and less likely to delay seeking care [8, 9].

This empirical evidence is bolstered by legal and ethical principles. The *AMA Code of Medical Ethics* [10] makes clear that patients have the right to choose their clinicians. An analysis in the *UCLA Law Review* that explored this issue came to a similar conclusion. The author argued that accommodating a patient's preference for a physician of a particular race or ethnicity is consistent with most prevailing medical ethical principles, including informed consent and respect for autonomy, and that no existing civil rights legislation could be used to bar this practice [11].

So why does selecting a physician based on race still make us uncomfortable? It's a matter of context. Our country's sordid history of race relations heightens our awareness when race enters into ethical decisions and the practice of medicine.

Were the patient in the scenario white, some of us would instinctively declare her racist. Is Ms. Smith any different? Had she merely said, "You know, I really like you. I mean, Dr. Chen is good, but sometimes I can barely even understand what he's saying"—we might be more inclined to acquiesce, believing the problem to be one of communication style and interpersonal relations. After all, poor communication can negatively affect the therapeutic relationship, and race concordance could lead to better outcomes and a better experience of care. But things change drastically when she continues, "You know? The accent? I mean, everywhere you go now it's immigrants." Here, Ms. Smith betrays her xenophobia.

This exchange highlights the importance, and subjective challenge, of perception. Our perceptions of a patient's beliefs impact our gauge of the validity, and the ethical ramifications, of acquiescing to his or her request. It is not Ms. Smith's request that bothers us, but rather our inference of the opinions that underlie this request. When we feel she is bigoted, our belief in the validity of her request instinctively decreases.

Where does this leave us with Ms. Smith? Evidence [3, 4, 6] shows us that if she is cared for by Dr. Simms, the quality of the care she receives, and her experience of care, will most likely improve. Could this added comfort be the reason she discussed her new mole with Dr. Simms during their first visit? Furthermore, her right to choose a race-concordant physician is consistent with several fundamental principles of medical ethics as well as existing legislation. Despite all of this, her comments have made Dr. Simms, and us, a little wary of her opinions.

Dr. Simms's Dilemma

At the center of this case is how we navigate our personal discomfort and negotiate a solution that is consistent with our values and Ms. Smith's expressed preference that she be cared for by a different physician. We believe Dr. Simms has two simultaneous imperatives that apply to any physician navigating this situation, regardless of physician or patient race.

The first is to respect the patient's articulated preferences. For the reasons outlined above, it is critical that Ms. Smith be able to select a physician of her choosing. The case brings to mind an encounter early in one of the author's (SJ's) internship in which a 76-year-old African American patient said, "it sure is nice to see a young Negro doctor." SJ is not African American and told the patient as much, but grasped that the patient might feel some added comfort being cared for by an African American physician. Patients are not required to feel equally comfortable with all clinicians, and we must try to understand the factors that contribute to this comfort and help patients find their way to clinicians with whom they are the most comfortable.

The nature of the primary care patient-physician relationship is such that if the patient enters into it half-willingly she may not have the trust in her physician that is necessary for a productive relationship. Ms. Smith expresses frustration with inability to understand Dr. Chen, something that can directly detract from their therapeutic alliance.

Dr. Simms's second imperative is to be consistent with his own values and feelings. He must address whether the patient's prejudiced views will impact his and his partners' relationship with the patient and impair their ability to provide high-quality, patient-centered care. Dr. Simms does not need to turn his relationship with Ms. Smith into a lecture on the importance of tolerance, but he should be free to express his discomfort if it could directly impact her care. Ideally, by discussing their

concerns with candor, Dr. Simms and Ms. Smith can understand each other's views and make a decision regarding her care that is consistent with both of their values.

Medicine's Dilemma

Above we offered our thoughts on how to manage a patient's preference for a race-concordant physician within the patient-physician dyad. It is equally important to consider how to manage these requests at the system level. Should hospitals and health systems institute policies for honoring or denying requests for race-concordant physicians?

As we discuss earlier, the personal and ethical challenges of these scenarios stem from our belief of the opinions that underlie a patient's request. Our health care system has neither the ability nor the resources to systematically assess these opinions. Any blanket policy, recommendation, or ethical guidance could hardly anticipate every situation. Furthermore, despite how uncomfortable it makes us, patients have the ethical and legal right to choose their physicians. Physicians, in turn, should be free to react to these preferences if they find them uncomfortable or objectionable, because they should be present in the encounter not merely as professionals but as people.

There are important exceptions and limitations. For example, we are told that the scenario takes place in a small town where concordance may not be possible. In settings where physicians are abundant, we believe that physicians and patients have more flexibility to choose one another. In smaller communities, where there are fewer choices, the obligation is greater to make the relationship work because patients do not have alternative sources of care.

If medicine is to truly embrace patient-centered care, we must try to match patients with the physicians with whom they will forge the strongest relationships and attain the best health outcomes. Race is just one dimension of the complex interplay behind the patient-physician relationship, but a meaningful one for many patients [12]. While we hope that society eventually arrives at a place where race is not part of this equation, for the time being, it is.

Conclusion

Acknowledging patient autonomy and the primacy of patient choice does not absolve us, as individual physicians or as a profession, of taking an active role in trying to alter the roots of Ms. Smith's preferences, and those of other patients for whom bigotry, racism, and xenophobia impact the choice of physician. The discomfort that comes from hearing Ms. Smith's request should not be met by passive acquiescence. Rather, it should serve as a reminder of the responsibility to use the position of medicine to expand cultural awareness, and continue to train all of our clinicians to provide culturally sensitive care. The fact that race concordance leads to better care is not a universal truth, but a modifiable outcome.

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