

## FROM THE EDITOR

### What Are Reasonable Limits to Patient Preferences About Their Caregivers?

C. Noelle Driver

In August 2017, people self-identifying as white nationalists rallied in Charlottesville, Virginia, to protest a city council decision to remove a Confederate monument from a public space. Protestors clashed violently with counter-protestors, and the weekend culminated with a white supremacist pummeling a group of counter-protestors with his car, leaving many injured and a young woman dead.<sup>1</sup> The governor declared a state of emergency and news of the protests spread. Reaching Portland, a city with its own unique history of white supremacy,<sup>2</sup> news of the violent rally kindled a response from Esther Choo, an emergency medicine physician at the Oregon Health & Science University. She posted on Twitter that white supremacy affects her ability to practice medicine; some patients refuse to be treated by her solely because of her Korean ancestry.<sup>3</sup> This revelation resonated with clinicians across the country; her post has received thousands of likes,<sup>3</sup> and Choo appeared on *CNN* to discuss the issue of patient discrimination against clinicians.<sup>4</sup>

Patients are typically the most vulnerable persons in health care encounters. A basic tenet of patient-centered care is expressing respect for patients' preferences, as they are expressions of patients' generally recognized right to self-determination.<sup>5</sup> Patients' preferences can inform clinician allocation; in some nonacute settings, such as primary care or gynecology, clinician assignment or reassignment based on patients' preference for a physician of a specific gender is routine practice, which is seen by many as reasonable deference to a patient's comfort.<sup>6,7</sup> While physicians have legal obligations to stabilize patients in acute emergencies,<sup>8</sup> regardless of prejudice or bias those patients might express against them, should there be limits to patient preferences in noncritical settings, particularly when these preferences express unjust bias or discrimination? This issue of the *AMA Journal of Ethics* explores the complexities of responding to patients' unjust bias and requests for patient-clinician concordance in individual patient encounters.

How should a clinician respond to an unjustly biased or prejudiced patient? In a case of a white supremacist patient and a trainee of color, Cory D. Mitchell proposes [affect labeling](#), or naming of emotions, to help both patients and clinicians identify and respond to negative emotions. Sharing his personal experience as an orthopedic surgery resident physician, Christian A. Pean asks, How should one respond to such requests in an ethnically responsible, pragmatic, and professional manner? He offers guidance to

organizations and clinicians about [how to respond to bias incidents](#). Similarly, Dionne Hart describes her experience of [discrimination in correctional health care](#), especially challenges discrimination poses to one's general obligation, as a health care professional, to clinical neutrality. Taking both a patient's and a physician's perspective, Samuel Dubin reflects on his own experience of [feeling stigmatized](#) when seeking a prescription for pre-exposure prophylaxis.

Responding to bias incidents extends beyond individual patients and clinicians to health care organizations. Kimani Paul-Emile suggests [5 protocols](#) organizations can implement to support clinicians who experience or witness bias incidents: assessment, debriefing, convening a team meeting, event tracking and data collection, and initiating institutional cultural change. Ann Marie Garran and Brian M. Rasmussen argue that organizations must work to train both professional and nonprofessional staff and enact [policies for responding to discrimination](#) against employees and patients. And Rahma M. Warsame and Sharonne N. Hayes describe the content, goals, and creation of [Mayo Clinic policy and procedure](#) to address discriminatory behavior when "zero-tolerance" is not possible.

Finally, this issue examines the ethics of patient-clinician concordance requests. Jacob A. Blythe and Farr A. Curlin analyze a case in which a patient requests a primary care clinician concordant with her [religious values](#); they argue that patient-physician concordance can enhance medical practice in certain circumstances. Leah Z. G. Rand and Zackary Berger discuss mixed evidence of [patient-clinician concordance](#) and argue that clinician reassignment requests must be scrutinized for a reasonable justification, such as conscientious objection. And John R. Stone considers [simplicity as an ethical value](#) in transitioning a traumatized patient from pediatric to adult psychiatric care.

Health care settings are not free of prejudice and discrimination. How to handle ethical issues related to their expression in clinical settings should be considered individually and organizationally by caregivers, administrators, and policymakers. It is my hope that readers of this issue of the *AMA Journal of Ethics* will turn a critical eye to the various species of prejudice and consider how contributors' sharing of their experiences and analyses might take us closer to a more just health care system and society.

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