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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.¹ 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,² 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.³ This revelation resonated with clinicians across the country; her post has received thousands of likes,³ and Choo appeared on *CMN* to discuss the issue of patient discrimination against clinicians.⁴

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.⁵ 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.^{6,7} While physicians have legal obligations to stabilize patients in acute emergencies,⁸ 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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CASE AND COMMENTARY

How Should Clinicians and Trainees Respond to Each Other and to Patients Whose Views or Behaviors Are Offensive?

Cory D. Mitchell, D.Bioethics, MA

Abstract

This commentary responds to a case in which a senior resident physician, an attending physician, and a medical student who is a person of color treat a patient expressing racial bias. By applying affect labeling (naming of emotions), this commentary illustrates how to balance patient preferences with a duty to treat and demands of justice in a way that can be healing for all stakeholders.

Case

Mr K is a 75-year-old man who presents to the emergency department at a metropolitan teaching hospital after falling in his home. SM, a fourth-year medical student who self-identifies as African American, notes that Mr K is agitated, confused, holds a confederate flag handkerchief, and has a faded Aryan fist (a white supremacist symbol) tattooed on his arm. SM is on a team consisting of an attending physician and 2 residents. SM begins to interview the patient by asking, "Mr K, can you tell me where you are?" Mr K turns to SM and shouts, "The 'hood!"

"No, Mr K, you are in the emergency department; you fell at home," SM clarifies. Mr K frowns and then his eyelids flutter closed. SM approaches Mr K, preparing to rock Mr K's shoulder to check his consciousness, but then pauses, afraid of Mr K's response. SM decides not to touch Mr K and leaves the room. Dr T, the senior resident physician standing just outside Mr K's room, asks, "What'd you learn about this patient? Let's go through the history."

"Dr T, I do not feel comfortable continuing Mr K's physical exam," reports SM.

"Why?" asks Dr T upon walking closer to Mr K. Dr T spots Mr K's handkerchief and tattoo, thinks, *Oh, I see*, and wonders what to do.

Commentary

Although this case raises many ethical questions, I focus on one here: Should racist symbolism displayed by Mr K influence SM's response to the patient? We will assume for sake of argument in this case that the patient's tattoo expresses his current—not just

his past—views on white supremacy, although it is worth noting that, in some cases, such an assumption could be worth questioning. In emergencies, a physician's duty to care should transcend his or her personal responses to racist symbolism and even take precedence over a patient's expressed wishes in emergent situations.¹ However, if a patient's speech or behavior is threatening, the patient's care may need to be transferred to another physician who does not challenge the patient's preference for a racially concordant clinician. Hand off among clinicians, if time allows, should entail some sort of formal ethics consultation.

It is important to note that reactions by persons of color to racist symbolism and images imbued with hate are not chosen in the sense that one chooses the color blue over the color green. Responses to racism tend to be visceral rather than intellectual. In this article, I argue that refusal to treat solely on the grounds of a patient's expression of bias is never morally justified. I suggest how *affect labeling* can be an effective way for an offended clinician to process and overcome a visceral reaction to offer superb care to a patient wearing symbols suggestive of the patient's assumption of racial superiority.

Decision to Treat and Affect Labeling as a Coping Strategy

Decision to treat. Paul-Emile and colleagues have proposed a decision tree for use in emergency settings when a patient has rejected a physician on the basis of race.¹ Following this decision tree, Dr T and SM should first assess Mr K's medical condition. If the patient is unstable, they should treat Mr K regardless of a patient's racial bias because Mr K could be suffering from delirium, psychosis, or dementia; refusal to treat the patient in such cases is unacceptable because such a cognitively impaired patient is not responsible for his or her actions.¹ However, I argue that, once a patient is stable, Dr T should recognize that repeated exposure to racial discrimination can result in a cascade of biopsychosocial sequelae for SM, including elevated blood pressure and cortisol, increased heart rate, hypervigilance, amygdala activation, aggression, risk of depression, and increased incidence of substance use or abuse,² and thus he should seek to intervene to the best of his ability. Appropriate intervention may entail requesting an ethics consult.

Affect labeling. However, some amelioration of the situation is within every clinician's grasp. One potential approach is to use affect labeling to get both SM and Mr K to put their emotions into words. Affect labeling is an evidence-based approach to regulating emotional states that can result from anxiety-producing stimuli.³ SM's reaction to the confederate flag handkerchief and Aryan fist tattoo suggests that he is experiencing some degree of emotional distress. Likewise, Mr K's response to SM (uttering that he's in "the hood") suggests that SM's presence is an emotional trigger for Mr K. Clinicians faced with a patient's race-based bias must balance the ethical principles of [respect for autonomy](#) against the equally weighty principles of justice and nonmaleficence—not just for the patient, but for themselves and their fellow clinicians as well. In what follows, I suggest an approach to achieving such balance.

Strategies for Intervening

Affect labeling by the medical student. When the situation permits, Dr T should address SM's feelings by asking SM why he does not feel comfortable continuing Mr K's physical exam. Based on my personal experience, I know that there are times in clinical settings when racist symbols or speech simply surprise us African Americans, and at times that experience is difficult to articulate—especially when a person of color is the clinician and the person implicitly or explicitly expressing racist attitudes is in need of care. Dr T can help SM navigate this role conflict by providing SM with affect labels such as shocked, surprised, upset, hurt, sad, confused, or angry. This type of affect labeling can modulate emotional, neural, autonomic, and behavioral responses to aversive stimuli.⁴⁻⁷

Affect labeling by the patient. Once Dr T has helped SM process and articulate his emotions, he can do the same with Mr K if necessary. In order to determine if affect labeling would be appropriate with Mr K, Dr T should request a psychological consult to assess Mr K's cognitive state and any potential barriers to following a treatment plan, such as adverse life experiences or refusal to follow an African American's instructions. If the patient is not opposed to being treated by SM or is cognitively impaired, affect labeling may not be appropriate. However, if Mr K expresses a desire not to be treated by SM, Dr T can help Mr K connect his emotions to his experience and thereby reduce his anxiety. For instance, Dr T could say, "When SM is in the room, how does that make you feel? So how does it feel when I tell you that SM is one of our finest physicians and that he is capable of providing you with excellent care?" Dr T could have an initial conversation with Mr K in order to accomplish this goal. However, a subsequent conversation should take place with Mr K, Dr T, and SM together in order to facilitate trust, dialogue, and learning. The rationale for this approach is to give both the patient and the clinician a chance to process and reconcile negative emotions in a way that is safe and conducive to healing for all involved parties. Eventually, one would expect SM to handle situations like this one on his own, so Dr T must be explicit with SM about what he is doing pedagogically.

Organizational Responses

Racial discrimination is detrimental to communication in health care relationships.⁸ Whenever and wherever communication breaks down, care is undermined.⁹ Thus, health care organizations have ethical and operational responsibilities to facilitate communication across all levels of the organization.

Affect labeling via expressive writing. In order to facilitate communication in situations like this case scenario, policies for dealing with patient bias in clinical encounters can be helpful. Medical schools and teaching hospitals are especially well equipped to help medical students and residents learn protective practices, such as [expressive writing](#) in response to bias incidents.¹⁰ These institutions could require that students write about their emotions in response to people or symbols that are racist or threatening as a

means of affect labeling. Fifteen to 20 minutes of expressive writing about disturbing events over a few sessions has been shown to result in long-term reduction of harmful symptoms stemming from adverse emotional responses to noxious stimuli.¹¹ Medical education would be greatly enhanced if all stakeholders' experiences of bias could be reported and evaluated, perhaps through an expressive writing exercise that could be submitted to a staff bioethicist, for example, for consideration and response. Specifically, the staff bioethicist could evaluate whether and how the clinician or student connected his or her emotions with the experience of emotional threat induced by symbolic communication or other expressions of discrimination.

System-wide use of affect labeling. All clinicians should be taught to respond to racist symbolism through ameliorative practices such as affect labeling. Affect labeling heals through communication and dialogue—through language—which can build a better health system. Affect labeling is one way of increasing psychological safety in situations that are emotionally laden but morally ambiguous due to the conflict between the fundamental, overarching duty to treat and the principles of respect for autonomy and justice as they apply to clinicians as well as patients. Because of the potency of this intervention, all clinicians should be able to engage others in affect labeling. This practice can take place among clinicians themselves, between clinicians and patients, or between clinicians and other staff members as needed. So Dr T should be trained in and highly supportive of this approach to emotional regulation for the benefit of SM as well as Mr K. Dr T is also well positioned to mediate discussions between SM and Mr K. It is through safe encounters with others that we grow as persons.¹² A health system that fosters such dialogue is better prepared to care for its own clinicians as well as patients.

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The people and events in this case are fictional. Resemblance to real events or to names of people, living or dead, is entirely coincidental. The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

CASE AND COMMENTARY

How Should Physicians Respond to Patient Requests for Religious Concordance?

Jacob A. Blythe, MA and Farr A. Curlin, MD

Abstract

In which ways and in which circumstances should institutions and individual physicians facilitate patient-physician religious concordance when requested by a patient? This question suggests not only uncertainty about the relevance of particular traits to physicians' professional roles but also that medical practice can be construed as primarily bureaucratic and technological. This construal is misleading. Using the metaphor of shared language, this article contends that patient-physician concordance is always a question of degree and that greater concordance can, in certain circumstances, help to obtain important goals of medicine.

Case

Ms L is a 78-year-old woman who presents to a primary care clinic to establish care with a new physician, as she has recently moved. She is assigned to a newer physician on staff, Dr O, who chats with her briefly and then begins to interview Ms L. Within a few minutes of Dr O's questions about her health history, Ms L mentions her faith. "I found Jesus a long time ago," she says sincerely. "Do you believe in God?"

Dr O is surprised but doesn't show it. "Yes, I do. Is it okay if we focus on your medical history for now?"

Ms L pauses for a moment and goes on about her faith's importance. "An essential part of who I am is that I believe in God. I believe in Jesus. What God do you follow? Is it Jesus, Allah or another god?" Dr O tries to focus on how to move on to obtain the rest of Ms L's history, and replies, "I believe in Jesus and Allah, too." Ms L straightens her spine and immediately replies, "No, you can't follow both."

Dr O doesn't reply and moves on to her review of systems. "Do you know if there is a Christian doctor here?" Ms L interrupts.

Dr O replies, "I'm new to this clinic and don't really know the religious affiliations of my colleagues." Dr O pauses and considers whether to continue examining Ms L.

Commentary

This case could be approached successfully in a variety of ways. We advocate a case-by-case approach to similar impasses, which call for wisdom and finesse. Accordingly, we caution against policies that would rule out any number of responses (eg, accommodation, partial accommodation, resistance) that might fit a specific clinical environment and patient.

We do recognize, however, that this case invites us to consider a wider set of difficult cases encountered by physicians—namely, cases in which a patient seeks out a physician who is concordant with her along some dimension (in this case, religious affiliation). This wider set of cases prompts an important question: In which ways and in which circumstances should institutions and physicians facilitate patient-physician concordance when such concordance is sought by a patient? This question involves considerations of justice (Are similar patients being treated similarly?), physician duties (Are physicians obligated to accommodate reasonable patient requests?), and the roles of health professionals in a pluralist society (Which aspects of physicians are relevant to their professional roles and why?). (We restrict our commentary to patients' requests for concordance, since physicians' requests for concordance involve additional ethical considerations.)

Are Particular Features of Physicians Relevant to Their Professional Roles?

Requests for religious concordance may stir controversy because of concerns about justice or the understandable desire to preserve strict **professional boundaries**,^{1,2} but each of these motivations may reflect the medical profession's underlying uncertainty about the relevance of individual characteristics to professional roles. Resistance to facilitating religious concordance is consistent with calls for physicians to set aside their particular characteristics (eg, religious affiliation³) when they don their professional role, but such calls are grounded in a false presumption—that the practice of medicine is primarily a bureaucratic and technological venture.⁴

On this construal of medical practice, the physician is characterized as an interchangeable and "anonymous functionary"—a characterization of moral worthiness when associated with "proper procedure," as the intrusion of the physician's particularity becomes a threat to the procedures that preserve the medical bureaucracy's pretense to fairness.^{4,5} The requirements of bureaucracy and technological production conspire to characterize particularity as either corrupting (bureaucracy's concern) or as a threat to predictability and reproducibility (technological production's concern); in this frame, particularity threatens hopes of achieving medical practice that is efficient and fair.^{4,5} Within the bureaucratic imagination, the only relevant features of individuals are those that mark them as holders of bureaucratic offices (ie, physicians) or as clients of such offices (ie, patients).^{4,5} As clients, patients are *assumed* to desire and need representative professionals, not idiosyncratic individuals.

Concerns about efficiency and fairness are appropriate when considering general clinical encounters between “moral strangers,”⁶ but such concerns do not preclude facilitating clinical encounters between *moral friends*. Ms L’s queries suggest that she is seeking a moral friend whom she can trust to promote her health in the context of a particular moral landscape. Accommodating such a request can be accomplished without threatening fairness, whereas refusing such a request is likely to hinder Ms L’s physician from practicing good medicine and Ms L from participating fully in a physician-patient relationship. Thus, reflexive resistance to facilitating religious concordance due to concerns about fairness or efficiency prioritizes the demands of a vision of medicine that may not lead to the best care for some patients. Moreover, in some cases, it seems quite possible to meet the demands of efficiency and fairness while simultaneously facilitating clinical encounters between moral friends.

The possibility of religious concordance promoting the practice of good medicine in some cases alerts us to the reality that the practice of medicine is not primarily a bureaucratic and technological venture and that arguments grounded on such a construal go astray. In contrast, we maintain that each patient and physician is an irreducibly particular individual with a manifold identity, only one aspect of which is described by the role of patient or physician. While these roles certainly entail commitments, these commitments do not require the wholesale repudiation or concealment of one’s manifold identity. It is neither possible nor wise to attempt to strictly separate the personal from the professional; to do so involves eradicating deep, often idiosyncratically grounded, commitments—eg, a personal commitment to serving those in need—that are often prized in those who enter medicine. Setting aside this false dichotomy between the personal and professional, how should physicians navigate concordance or discordance with their patients along different dimensions?^{1,2,7-9}

Concordance as One Strategy for Realizing Current Ethical Ideals

It seems uncontroversial to say that the competent physician pays attention to psychological and social features that may affect patient care. A physician’s capacity to pay attention—and to facilitate wise decisions in light of what she recognizes—can be enhanced in some cases when there is concordance of one form or another between a physician and a patient.

To select a common example, it may be that any competent physician can, with the help of an interpreter, treat a patient who speaks a different language, but a physician who shares the primary language of the patient has presumably *more capacity* to elicit salient information, understand context, and respond appropriately to what the patient says. The aforementioned “more” is not required by the professional role, but it does seem to facilitate the achievement of goods that medical professionals rightly pursue. Concordance, in this case, enhances the practice of medicine. The example of [language concordance](#) relates to the case described above, as religious discordance can be viewed

as the absence of a “common vocabulary” and context—in short, as the absence of a shared language.¹⁰

Using the example of language concordance as a paradigm case, we suggest that concordance of moral vision and “moral language” may help physicians recognize and respond to salient features of individual patients. While any competent physician can treat Ms L, she might be best served by a physician who speaks her “language,” understands her traditions of thought and practice, and can respond in light of any salient nonphysiological information that emerges due to this shared context.

Of course, a request for concordance can express not a need for a shared moral language but a form of invidious discrimination, such as when a patient insists on being treated by a white physician. Facilitating such requests is obviously unacceptable, and it is possible that Ms L is motivated less by a desire for shared moral language than by a disdain for non-Christians. Distinguishing cases that deserve accommodation from those that should be resisted is no small feat, and it calls for difficult moral discernment in some cases. But, in the present analysis, we presume Ms L is acting in good faith, and this assumption seems fitting as a first response to most patients.

Returning to the notion of moral vision and moral language, each patient and physician enters a clinical encounter steeped in particular traditions of thought and practice, which inform their moral evaluations of available goods (medical and nonmedical) and their judgments about how medicine fits into the pursuit of those goods. Accepted ideals of medical practice, such as shared decision making (SDM), informed consent, and goal-concordant care, recognize this evaluative aspect of clinical encounters.¹¹⁻¹⁶ SDM attempts to rectify asymmetries between patients and physicians by promoting, at a minimum, the transfer of information from physician to patient and the transfer of values and preferences from patient to physician, recognizing that the moral evaluation of courses of action bears heavily on whether they are medically appropriate.^{11,12,14} SDM hopefully leads to a joint decision informed by both medical expertise and patient values. In a similar vein, a primary goal of informed consent—on some readings—is to assist the patient in making treatment choices that accord with her inherent stable values, once again recognizing the importance of the moral evaluation of medical therapies.¹³ Recently, the concept of goal-concordant care has risen to prominence as a way of describing care that accords with a patient’s goals and respects the limitations she desires; some authors have even suggested that failing to achieve goal-concordant care may constitute a medical error.^{15,16} All 3 of these ideals—SDM, informed consent, and goal-concordant care—highlight the reality that health is a real good, but it is not the only good. All patients must eventually decide how to choose among the various available goods and to what extent to cooperate with physicians in doing so.

The physician who attempts to achieve the ideals represented by SDM, informed consent, and goal-concordant care is tasked with attending to the patient's past and present in order to envision and propose clinical care plans that reflect the physician's commitment to the patient's health and accord with the particular characteristics, preferences, and interests of the patient.¹³ In making these proposals, the physician respects the patient's authority to decide whether and to what extent she will cooperate with the physician to pursue various courses of action among the many available (some of which may contradict the physician's medical recommendations). In some cases, the patient's particularity will influence the very proposals the physician offers. This process of mutual accommodation can fail, and some failures will be traceable to blindness on the part of physicians—blindness that might have been overcome by concordance of moral vision and moral language.

Such blindness may be rooted in the medical context. The medical context has been described by Taylor as "a community defined by the shared cultural conviction that its shared convictions [are] not in the least cultural, but, rather, timeless truths."¹⁷ Taylor pithily describes this as "a culture of no culture."¹⁷ In this frame, the physician is presumed to be neutral—as Dr O is characterized—and any discordance is a matter of the neutral medical-scientific perspective (often portrayed as normative) coming into conflict with a particular (in this case, religious) culture. Ms L's reaction to Dr O exposes the weakness of this claim of physician neutrality. Ms L indicates that the religious commitments of her physician matter to her. Dr O might be able to demonstrate respect for Ms L without sharing her values, but Dr O will have to concede that she is not an interchangeable representative of the medical profession. She is, rather, a physician who comes to medicine with convictions that differ from those of her patient, which might make a difference for the care she offers Ms L. Put differently, in the dance that is medical practice, medical facts are not merely given; as Kuczewski writes, uncovering medical facts involves a "value-laden thought process.... Such values may simply come from the standard of care and the clinical culture, but they will sometimes be colored by the physician's own experiences and, quite possibly, personal values."¹⁸

We suggest that proceeding from the predominant cultural commitments of a culture of no culture can hinder physicians from achieving medical goods. To provide one example, Hasnain et al have argued on the basis of their qualitative research that "Muslims ... have in common a religious thread that impacts the entire spectrum of their health-related beliefs and practices."¹⁹ Accordingly, Muslims, particularly Muslim women, have a diverse set of **religious and cultural needs** related to health and, as Hasnain et al note, "lack of providers' attention to these needs compromises the provision of quality care and contributes to Muslim women's reluctance to seek and use healthcare services."¹⁹ In their study, most challenges reported by clinicians in treating Muslim women centered on clinicians failing to understand these patients' religious and cultural needs.¹⁹ While ignorance can be overcome by education, it also can be mitigated by concordance at the

level of religious affiliation and gender. Moreover, the public appears to suspect that physicians' distancing themselves from patients' cultural commitments (ie, proceeding from a culture of no culture) sometimes hinders their care. One survey found that 43% of respondents were "very" or "somewhat" concerned that "medical personnel might not understand how your culture affects the type of treatment you would like to receive."²⁰

Conclusion

The clinical encounter is steeped in and inevitably shaped by the values of both physicians and patients, and concordance is always a question of degree. Physicians who resist requests for concordance may have uncritically accepted a role as an anonymous functionary working in a culture of no culture. We contend that this posture will sometimes prevent a physician from recognizing the goods and values at stake in a request for concordance and in the medical decisions that patients face. This is not to say that all requests should be satisfied, but it is to argue for cultural humility rather than a presumption of neutral cultural competence in assessing such requests.²¹ As Tervalon and Murray-García note, such humility requires that we are "flexible and humble enough to say that [we] do not know when [we] truly do not know and to search for and access resources that might enhance immeasurably the care of the patient."²¹ Occasionally, the best resources we have may be our colleagues, who—because of their concrete particularity—may be able to better provide what the patient needs. A diverse community of physicians makes such accommodations possible; physicians with specific traditions of thought and practice are sometimes best situated to bring to bear what medicine offers and to do so in ways that fit the needs of patients with similar traditions of thought and practice.

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CASE AND COMMENTARY

Does a Patient's Trauma History Ethically Justify a Discriminatory Clinical Referral?

John R. Stone, MD, PhD

Abstract

This article analyzes a child psychiatrist's referral approach when the patient's care must be transferred to an adult psychiatrist and the otherwise best adult psychiatrist has "accented" language, which is associated with the patient's prior trauma. The analysis considers the value of simplicity and a related "simplicity strategy," revealing that many ethical factors lay behind the simplicity approach. The inquiry then addresses simplicity regarding practical wisdom and context. The paper argues that simplicity should mean considering just what's relevant and no more. Applied to the case, simplicity includes respect for persons, openness, honesty, trustworthiness, beneficence, nonmaleficence, ethics of care, professional empathy, group inquiry, epistemic humility, and justice. An objection regarding undue complexity is noted and refuted.

Case

SR, age 18, has seen her child psychiatrist since age 16, when she witnessed her sister's sexual assault by a home intruder. The perpetrator shouted with a heavy accent during the incident. Since then, Dr J, the child psychiatrist, has helped SR reduce her fear of men speaking accented English. When SR turns 18, Dr J states that she should transition from Dr J to continued therapy with an adult psychiatrist. "OK," says SR. "I hope the new doctor's as nice as you."

Dr J knows many adult psychiatrists who could further assist SR with her posttraumatic stress. Dr J especially prefers Dr C, who has often helped Dr J's other patients needing comparable care transitions. However, Dr C's English is heavily accented. SR has not explicitly favored an adult psychiatrist who speaks nondescript English, but Dr J naturally worries that Dr C's speech pattern would further traumatize SR. Dr J is uncertain about disclosing Dr C's personal characteristics to SR because such disclosure might discriminate against or disrespect Dr C. On the other hand, Dr J worries whether it would be ethically or clinically appropriate to refer SR to Dr C without alerting SR to the language issue. Dr J could refer SR to other adult psychiatrists, but Dr J thinks they would be less effective than Dr C.

Commentary

I sometimes envied clinical colleagues who saw clear clinical options for a patient while nuanced possibilities swirled in my brain. Their mantra might well have been “KISS,” the well-known acronym for “Keep it simple, Stupid!” Constructively, I take KISS to mean that wise approaches avoid extraneous factors. That is, simplicity is clinically helpful. Avoiding the pejorative “Stupid,” perhaps a simplicity strategy labeled SS captures Dr J’s best response.

Simplicity as an Ethical Value

In the case of SR and her child psychiatrist’s referral dilemma, 3 alternative scenarios suggest how the value of simplicity can illuminate factors of ethical relevance.

Scenario 1. Let’s suppose SR is legally an adult with sufficient capacity for health care decisions. Further suppose that Dr J recommends Dr C to SR, explaining Dr C’s “accent” issues. To SR, Dr J might then state: *Given your great progress, I think you will quickly work through negative reactions to Dr C’s speech. Your usual fear response should be shorter and less intense. Dr C is really wonderful. I suspect you’ll quickly move beyond or accept his accent. Working with Dr C seems your best route to continued recovery. However, I certainly will honor your decision to see another psychiatrist. A good but second-best psychiatrist would be Dr D. I suggest mulling over this choice a few days. I’ll arrange an appointment with Dr C, D, or another psychiatrist you would prefer. Also, SR, I would be fine with your choice for someone besides Dr C. Our relationship won’t suffer.*

In blunt (SS) shorthand, some might ask, “What’s the problem?” SR is of age and has capacity. After Dr J explains the choices, SR gets to decide. Period. Simple enough. Moreover, Dr J is honest and open with SR, mentioning Dr C’s accented English despite being concerned about doing so. Dr J thus likely would maintain or enhance SR’s trust. And trust is doubly involved.¹ If Dr J refers SR to Dr C without alerting her to the language issue, either Dr J is professionally incompetent in ignoring potential harm, or Dr J is dishonest. Regardless, SR would probably consider Dr J untrustworthy. Then SR’s future trust in health care professionals could decline, undermining her later health care. (As philosopher Annette Baier noted, trust is hard-won and easily lost.²) In addition to issues of trust, if SR did not expect Dr C’s accent, her encounter with Dr C could be needlessly traumatic, contravening Dr J’s duties to do no harm and to do good. Also, Dr J’s ignoring SR’s risk for further trauma would demonstrate a failure of empathic insight and attendant caring responses.³ Dr J’s openness, respect for SR’s autonomy, and trustworthiness are the clinical ethical values that applying SS illustrates through this particular case variation.

Scenario 2. Let’s instead suppose Dr J recommends only Dr D, who speaks without an accent. Also presume SR later learns Dr J generally recommends Dr C rather than Dr D. SR thus decides that Dr J didn’t really consider her a mature adult and didn’t honor her

capacity to assess referral pros and cons. She determines Dr J is untrustworthy, but now for different reasons.

Given this adverse outcome, the SS approach of ensuring SR's participation in assessing her referral options again seems best. Clinical ethical values and duties support honoring SR's capacity and right to choose, as explained above. Also, if SR makes an informed choice to see Dr C, Dr J avoids treating Dr C unfairly. That is, Dr J avoids discriminating against Dr C for a speech pattern unrelated to Dr C's professional competence. As a justice matter, then, Dr J ensures that Dr C has an equitable opportunity to be SR's new psychiatrist while honoring SR's capacity to conjointly make a referral decision.

Scenario 3. Let's finally suppose that Dr J recalls his medical school ethics group. Faculty mentors promoted the value of collective inquiry when deliberating about puzzling cases. Faculty also recommended consulting published analyses and evidence. So Dr J consults his long-standing partner, who draws on experiences. The partner suggests talking with Dr C, who might have encountered comparable problems. Dr J talks with Dr C, who says something like the following: *Yes, some patients are first discomfited because I'm "different." If their diversity exposure is limited, they seem particularly unsure I'm a good choice. With those patients, I transparently acknowledge my otherness and how I might be different from them. My direct approach is typically successful. I honor patients' reasonable distrust (from their perspective) and openly address it. And, if you like, I can share my phrases and strategies for putting such issues, as I've learned to say, "on the table." I would follow this approach with SR. If she then wants to see another psychiatrist, so be it.*

In this scenario, Dr J twice used group inquiry. One source was his partner's family, educational, and professional background—indicating an extensive group membership. Moreover, Dr C, we might suppose, had discussed the language issue with other colleagues, families, and so forth. Dr C had learned from his actual experiences and had developed significant practical wisdom about how to address a concrete professional challenge involving patients' needs or preferences related to one of his personal features. By using group inquiry, Dr J reinforces respect and justice, keeping the patient's interests (rather than Dr J's own) central. And by using group inquiry, Dr J honors Dr C's professional skills while attesting that Dr C's accent is immaterial except for a particular patient's challenge. Hence, Dr J avoids unjust discrimination. Let's further suppose, then, that Dr J communicates Dr C's revelations to SR and then supports SR's informed choice.

In Scenario 3, the value of simplicity motivates drawing from collective inquiry. Practical wisdom generates the SS of asking a partner and directly consulting Dr C without divulging SR's identity. The approach is "simple" because it employs the clear idea of drawing from collective input and wisdom. Also, when applied to this particular scenario, the SS helps illuminate the importance of clinical neutrality and patient centeredness. Dr

J nonjudgmentally acknowledges SR's potential reactions to Dr C, consults Dr C, and focuses on ensuring SR's informed choice.

Simplicity, Complexity, and Practical Wisdom

In deciding what we health care professionals clinically should do, we must obviously assess all relevant factors. But—crucially—context matters. As a cardiologist (my first career), suppose someone needed urgent intervention. I had better draw on all relevant information available, say, in 15 minutes. Other pertinent facts might emerge over 24 hours. So what? Irrelevant in the moment. Without quick clinical action, the patient might die or be irreparably and severely damaged.

The SS means that I should just consider what's most relevant in those 15 minutes. I should not then worry about what would take 24 hours to learn. And my decisions, of course, are not just technically clinical but informed by my ethical orientation to urgency's practical necessities. I'm choosing (or recommending) what would be best for patients and minimizing harm while respecting their personhood, enabling their choices, treating them fairly in a caring manner, and doing so in the moment.

Simplicity as an ethical value suggests the importance of discerning all that matters clinically and ethically for a decision. But no more. Ethical choices are often complex in clinical care. (And elsewhere for that matter.) Analysis of SR and Dr J's case reveals this complexity. The superficial SS approach might jump on respect for autonomy—apparently end of story. But respect for autonomy actually resonates here with respect for persons, openness, honesty, trustworthiness, beneficence, nonmaleficence, ethics of care, professional empathy, and group inquiry. And, oh yes, justice and humility! To consult Dr C, Dr J had to admit he was unsure about what to do. If not, no consulting others.

Clinical and ethical practical wisdom ought to draw on this sophisticated sense of what the value of simplicity implies. The superficial SS could mean ignoring potentially relevant matters. But the SS unthinkingly applied produces lousy clinical or ethical judgments. We have to face what matters. But context constrains what matters for a given clinical or ethical decision. We must discern a [situation's boundaries and needs](#).

Objection and Counterargument

A critic of my scenarios and comments might argue that the approach produces outcomes that in sum are too complex: if clinicians actually tried applying this analysis, the multiple aspects would bog them down. Delayed judgments could then worsen patient outcomes. However, this hypothetical critic misunderstands clinical and ethical decision making. Seasoned health care professionals know that often many data sources and guidelines should influence their advice. Examples are lab tests, radiographic information, ultrasound images, MRI scans, more patient or family history, the patient's

clinical trends, [ethical principles](#), professional boundaries, and so on. Experienced clinicians efficiently sift and sort information from these sources. And practical wisdom includes humbly knowing how to promote mutual decision making with patients and when to request clinical and ethical consultation.

Conclusions

This paper discusses a child psychiatrist's referral options when a traumatized patient fearfully responds to accented English and the ostensibly best adult psychiatrist for her speaks with a heavy accent. Traced through 3 clinical scenarios, the analysis shows the value of simplicity in ethical clinical judgment. Employing simplicity initially seems straightforward: explain the patient's options and she can decide (ie, express respect for autonomy). However, many ethical factors underlie what seems simple; what seems simple is complex. The value of simplicity and the related SS mean considering just what's relevant, and no more. And what's relevant for respecting autonomy and applying simplicity here include respect for persons, openness, honesty, trustworthiness, beneficence, nonmaleficence, ethics of care, professional empathy, group inquiry, justice, and epistemic humility. An objection regarding the undue complexity of SS was refuted. Applying the SS shows how to acknowledge a patient's potentially discriminatory preference without making an inequitable or disrespectful clinical referral.

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CASE AND COMMENTARY

How Should Organizations Respond to Racism Against Health Care Workers?

Ann Marie Garran, PhD and Brian M. Rasmussen, PhD

Abstract

This case and commentary considers how organizations should respond to overt racism expressed by patients. The article considers the nature and scope of organizations' responsibilities to train both professional and nonprofessional staff and to enact zero-tolerance policies to address expressions of discrimination.

Case

Dr C, an African American, is in her final year of an internal medicine residency. She reports to the emergency department to examine a middle-aged white woman injured in a car accident. The patient appears in stable condition but likely requires further medical testing. In the midst of the examination, the patient blurts out, "Isn't there another doctor who can do this? I'd rather have a white doctor." Dr C, shocked but not surprised, asks the patient if she wants the examination to continue and the patient acquiesces. The patient mutters under her breath, "I guess this is the way the world is going." Dr C pretends to ignore the comment and continues the examination. The attending staff physician is an older white male, well respected in the organization. He observes the interaction and stands by quietly, allowing the examination to be completed. Upon leaving the patient's room, the discussion among clinicians focuses exclusively on which tests are to be ordered, leaving the matter of the patient's remarks unaddressed.

Commentary

That racism exists in health care settings should surprise no one—it exists in all domains of contemporary life. What is surprising is just how little racism is formally addressed in medicine.¹ Noting this neglect, Johnstone and Kanitsaki ask, "Why has racism per se tended to be poorly addressed as an *ethical* issue in health care ethics discourse?"² That is a good question. We know, for instance, that there are long-standing discrepancies in health care outcomes based in part on racial discrimination. These findings are not just historical facts but reflect contemporary conditions.³ Also well documented are racial assaults faced by health care practitioners of color, whether they be physicians, nurses, or other staff.⁴ Although inequalities in access to health care services and inequalities in health outcomes deserve our utmost attention, it is [racial assaults on health care staff](#) that we wish to focus our attention on here—from an ethical perspective. We are particularly interested in exploring not only the ethical problems that emerge when

health care workers are exposed to racial discrimination by patients they attempt to treat but also, importantly, the conditions under which these ethical issues can be optimally addressed.

Need for Organizational Responses

Not uncommonly, health care practitioners of color are subject to overtly racist behaviors by patients—for example, when an individual or family specifically requests a white clinician. As Paul-Emile et al argue,⁵ there are some reasonable motives for people to request someone other than the attending physician. Such requests may be rooted in [religious dictates](#), gender preferences, or language barriers. For example, with respect to gender, we recognize that in the case of sexual assault it would be reasonable for a female patient to request a female physician. While some might be concerned that there is a slippery slope in determining what qualifies as *reasonable*, for the most part, a physician dealing with these kinds of requests is not burdened by the demand. The same cannot be said for the refusal of a patient to be treated by a clinician of color. In this case, the emotional harm experienced by the clinician should not be underestimated.⁶ When faced by a racist attack, an ethical conflict emerges for health care practitioners of color between the duty to provide care and the duty not to treat patients against their wishes and to do no harm. Indeed, in certain situations, there are also legal requirements to provide care.⁷ In this scenario with Dr C, the ethical dilemma was averted, technically speaking, because the patient consented to Dr C's continuing the exam. Had the patient held firm in her refusal, the decision-making process of the physicians would first need to consider the medical condition of the patient and the necessary duty to provide care.⁵ But our interest here is the harm done to Dr C and the inaction of the staff physician. We wonder: What went through his mind when the patient made her request? What was his thinking as he walked away, offering no space for discussion or for Dr C to debrief? What prevented him from saying something directly to the patient? What prohibited him from engaging in a conversation with Dr C to elicit her experience of this encounter? What was Dr C to make of his silence? Is Dr C expected to manage her emotions on her own? If so, why is this expectation an acceptable one?

In addition to the harm done to Dr C by her mentors' neglect is the harm done to her by the patient's abuse, as is the case with other health care practitioners of color on the receiving end of racism.⁸ Indeed, there is a growing literature by health care practitioners that chronicles episodes of racial bias and discrimination and the emotional harm that they have experienced.⁹⁻¹¹ Accordingly, Paul-Emile and colleagues have provided guidelines (in the form of a decision tree) for emergency department physicians to consider when presented with patients' requests for reassignment based on race or ethnic background.⁵ The decision tree balances the duty to provide care to racist patients with recognition of the harm to targeted physicians by taking into account whether the patient is medically stable. However, the authors also state, "we believe that institutions should not accommodate patients in stable condition who persist with reassignment

requests based on bigotry.”⁵ Similarly, Rakatansky argues that when “there is no imminent danger of patient harm, the HCW [health care worker] or institution may, and I believe should, deny requests that are based solely on bias and bigotry.”⁴ Although there does seem to be some acknowledgment of this phenomenon of discriminatory reassignment requests, institutional responses have been slow in coming.¹²

How Should Organizations Respond?

Bear in mind that reassignment requests based on bigotry pose an *ethical dilemma* that does not lead to black and white solutions. The question then arises, Does a focus on policy solutions to the exclusion of staff training and awareness put the cart before the horse? The need for organizational policies and guidelines is unequivocally necessary. But without an informed health care work force that is motivated to provide nondiscriminatory care, aware of—and sensitive to—the dynamics of racism in myriad settings, and fully capable of holding difficult (patient-clinician or collegial) conversations in the heat of the moment and in the coolness of reflection, policies of respect and zero tolerance are mere moral proclamations. Health care organizations need to define what zero tolerance means within the constraints of the duty to provide care. They must first move beyond the current state of discrimination against clinicians being an “open secret,”¹² and they must acknowledge that reassignment requests motivated by bigotry are problematic and can, in fact, do harm. How these ethical dilemmas are addressed or resolved in real practice situations, though, has not been extensively researched.

Nevertheless, the question we can ask is this: What will it take to move beyond this current state of willful passivity or blatant disregard? Paul-Emile and colleagues present a convincing case for administrative and institutional duties in the face of expressions of racism.⁵ We concur with the authors that organizations must **identify and prioritize action steps** or risk losing talented staff members of color who refuse to be demeaned. It is critical that we acknowledge the full range of manifestations of racism in medicine rather than pretend that it does not exist. In addition to overt expressions of racism, so-called microaggressions recognize more subtle expressions of bias.¹³ A health care setting rife with microaggressions (ie, subtle slights and insults that serve to demean, marginalize, or otherize¹⁴) generates a profound sense of personal and professional invalidation among health care workers.^{10,15} Microaggressions are quite common in the current sociopolitical climate, as are overt expressions of bias and discrimination.

What does it take to effectively work towards a nonracist health care workplace environment? The burden ought not to be placed solely on clinicians of color. We do know that health care practitioners of color are hesitant to report experiences of racial discrimination to their white supervisors or administrators.¹⁶ Can white people step up to the challenge? What gets in their way? There are multiple ways of understanding the resistance to stepping up. DiAngelo coined the phrase *white fragility* to describe

a state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves. These moves include the outward display of emotions such as anger, fear, and guilt, and behaviors such as argumentation, silence, and leaving the stress-inducing situation. These behaviors, in turn, function to reinstate white racial equilibrium.¹⁷

Both microaggressions and white fragility leave a person of color in a state of disequilibrium, with nowhere to turn. The consequence of white fragility is that the wrong person has his or her needs met: the aggressor becomes the victim. For instance, in the case example, the staff physician may have felt the need to console, placate, or—at the very least—not offend the white patient, leaving Dr C to fend for herself. In view of these dynamics, Dudzinski suggests that white bioethicists “can step into white guilt and accept that grappling with it is an important part of the work we do.”¹⁸ Accordingly, health care administrators in their role as leaders must be at the forefront of raising awareness of and combatting white fragility.

Organizational leadership and support are key if institutions are to truly fulfill an antiracist mission, but that leadership and support require a firm commitment from all stakeholders in the organization.¹⁹ A desire to work towards eradicating racism in all its forms must underpin that commitment. Nonetheless, it is virtually useless to sponsor yearly cultural competence or diversity trainings, which do little, if anything, to address racism, power, and privilege on the interpersonal or institutional levels *in the absence* of concerted, ongoing organizational commitment. Given the ethical (and legal, in some cases) demands to provide care and not to treat patients against their wishes, zero-tolerance does not mean letting expressions of discrimination slide; rather, it means acknowledging what was said and addressing the racist behavior. What is required is the capacity, skill, and willingness to hold these difficult conversations and actually enforce, not just advertise, organizational policies.²⁰

Alternative Responses to Dr C’s Case

Finally, returning to our case example, what could reasonably have been expected of the staff physician? There is a range of possible actions that he could have considered undertaking: gently, but firmly, describing to the patient Dr C’s talents and what constitutes unnecessary or intolerable behavior; offering to debrief with Dr C immediately following the incident; or seeking counsel from colleagues. Each of these actions would have required an awareness of what transpired and the skill for intervention, however unpleasant, clumsy, or awkward. Imagine how meaningful it would have been had the staff physician responded by checking in with Dr C about the overt racism she had experienced. The ethical problems of racism are not put to rest simply because we have addressed a circumscribed ethical dilemma. Knowing that there is enduring harm for clinicians of color, it is indeed time to get on the horse.

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IN THE LITERATURE

Disentangling Evidence and Preference in Patient-Clinician Concordance Discussions

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Abstract

Debate about whether and when to accommodate patient requests for concordant clinicians should consider evidence. This article examines how existing evidence could be used to interpret or inform ethical arguments about whether to accommodate such requests. Studies on patient-clinician concordance yield mixed and inconclusive results. Concordance might contribute to increased patient satisfaction and trust, but these results are not consistent and could be the result of clinicians' communication skills. Given this evidence and the risk of social harm in honoring concordance requests, this article argues that patients' concordance requests should be honored only when health care services would be denied to a patient, such as in a case of a clinician's conscientious objection to providing a service. All other requests should be scrutinized for a reasonable ethical justification.

Concordance Requests

In this article, we review evidence about patient-clinician concordance—that is, shared characteristics like gender, race, or socioeconomic status—and discuss how it bears on the debate about whether to accommodate patients' requests for clinicians with specific characteristics. Patients may request a clinician with a specific characteristic for a variety of reasons, including personal preference, [religious values](#), or assumptions about who provides the best care. Some might argue that patients, as the vulnerable party, ought to have their requests accommodated but draw a line when preferences are based on socially unacceptable reasons grounded in prejudice, sexism, or racism.

To approach these ethically tricky questions, we examine evidence of the effects of patient-clinician concordance and whether it justifies accommodation. While the evidence does not resolve the ethical questions about when or why to accommodate patient requests, it can help distinguish types of cases and limit the kinds of arguments to accept to support accommodation. We start with 2 counterfactual evidence scenarios and describe commitments that would follow. Next, we discuss evidence of the effects of patient-clinician concordance, which suggests that reasons to accommodate a patient's request for a clinician with a specific trait are limited. Finally, we examine cases

in which a lack of concordance might imply that health care services would be denied to a patient. Such cases arise when patients and clinicians hold different views about what constitutes health care. We suggest a reasonableness requirement for assessing patients' concordance requests, a higher standard than mere preference.

Accommodating Concordance Requests

We begin by proposing 2 hypothetical cases about evidence for concordance.

First, suppose there is strong evidence demonstrating that patient-clinician concordance directly improves patient outcomes. We could improve health simply by matching patients to clinicians who are "like them." Patient requests for concordant clinicians would be justified as choices for more effective care. We could even go so far as to argue that there is a moral obligation to arrange concordance since to not do so would deny patients an effective intervention.

In this first hypothetical case, there could be negative consequences of intentionally arranging concordance despite its appearing justified. It would stretch the health system past capacity because there are not enough clinicians of a certain race or ethnicity (hereafter, "race") and **gender**, like black male physicians.¹ Instead of reducing health disparities between social and racial groups, in this scenario it would exacerbate them due to the lack of minority clinicians. Classifying patients by characteristics they are seeking in clinicians could also lead to increased stereotyping, social segregation, and xenophobia—intrinsically harmful social outcomes. Patients could be stratified into groups that reinforce separate but equal treatment, a harmful social paradigm (albeit one not eliminated in our own day). Another possible outcome of purposeful concordance is that it could reinforce negative patient views of clinicians as biased, views borne of social and political inequities manifest in black patients historically not being treated by white physicians.² Even given the putative clinical benefits of concordance, such deleterious social consequences would argue against it.

In the second hypothetical case, suppose there is strong evidence that patient-clinician concordance has *no* effect on patient care or outcomes. In this case, accommodating patient requests for a concordant clinician would not benefit patients. Since there would not be a medical reason for concordance, the justification would rest on the value of respecting patient preferences and choice. The importance of this case is to illustrate that if there is no evidence of effects of concordance, the possible justifications for accommodation narrow.

The medical system allows patients to make many choices based on their preferences, but requesting clinicians based on their identity characteristics is different since it is founded on personal, not professional, characteristics and can harm clinicians by exposing them to **discrimination**. (We acknowledge that personal and professional characteristics are often closely bound up since the exercise of a profession is not a

“view from nowhere”³ but of necessity subjective. We adopt this division, however, as a first approximation. For example, a clinician who is white and foreign born—both personal characteristics—may prescribe antibiotics less frequently because of her Dutch medical training, a professional characteristic.⁴) If there were no evidence demonstrating effects of concordance, patient requests would need to be scrutinized because of the potential harm to clinicians.

Concordance and Health Outcomes

The challenge is that the evidence of the effects of concordance lies somewhere between these 2 hypothetical cases, perhaps closer to the second: it is inconclusive whether concordance improves health outcomes. Few studies have shown any direct correlation between these 2 variables. The exception is evidence of better outcomes with [language concordance](#) between non-English-speaking pairs,⁵⁻⁸ although other studies discussed below have reported effects of concordance.

One argument for concordance is grounded in evidence that racial minorities receive worse quality care than their white counterparts²; concordance requests could be justified by a motivation to try to remedy this disparity. However, evidence is mixed on whether concordance alone will reduce health care disparities. Some studies found no relationship between racial concordance and improved outcomes, communication, or patient satisfaction.⁹⁻¹¹ Other studies found that both quality and type of treatment and communication are influenced not (or not strongly) by concordance but by patients’ or clinicians’ race or gender.^{10,12-17} Conversely, 2 studies have reported that racially concordant patient-clinician pairs are associated with increased medication adherence^{8,18}—presumably linked to better patient outcomes—and another study reported an association between concordance and reduced cardiovascular events.¹⁹ It is worth noting that all 3 of these studies examined racial concordance for black patients, with 2 of the studies including samples of Hispanic and Asian patients.^{8,18}

More consistently, studies have reported that patients were more satisfied with communication and their visits and had greater trust in their clinicians when they saw either racially or socially (gender-, education-, or age-) concordant clinicians.^{14,20-23} It seems reasonable to conclude that patients who have positive health care experiences and trust their clinicians will adhere to recommendations.²⁴ It could also be the case that clinicians similar to patients in some respects make patients feel more justified in reporting their experience, thereby mitigating epistemic injustice that occurs if patients are not believed because of their race or gender, for example.^{25,26} However, here, too, the concordance evidence is mixed, since other studies have shown that it is not racial concordance but the clinicians’ interpersonal and patient-centered communication that affects satisfaction and trust.^{10,27-29} The evidence thus cuts 2 ways: concordant clinicians may increase patients’ trust and positive feelings about the health care encounter, but clinicians who are well trained in communication and cultural competency can also cultivate patient trust.

Without clear-cut evidence of health benefits of concordance, the reasons to accommodate a patient's request for a certain type of clinician are limited. Although evidence about effects of certain shared characteristics is inconclusive, each patient-clinician relationship is unique, shaped by many preferences and values. In the next section, we examine the acceptability of accommodating some preferences through 2 examples. These examples form the basis of our argument that accommodating patient preferences for concordant clinicians should be dependent on reasonable justifications.

A Case for Accommodation, Sometimes

In this section, we examine 2 situations in which patient requests are motivated by evidence-based reasoning about outcomes and values. One leads to an absurd and unacceptable conclusion, and the other provides a reasonable justification for accommodation and concordance. Consider: several studies have found that, compared to male clinicians, female clinicians have better communication with patients and improved outcomes—from lower 30-day mortality rates and fewer emergency room visits to better detection rates of adenoma during colonoscopies.³⁰⁻³⁶ Assuming those studies capture true effects, which is similar to the first hypothetical case we proposed, it could be that when a patient—male or female—requests a female clinician, the reason is to receive better care. If a female patient requests a female clinician, is it because she feels more comfortable or wants to maximize the likelihood of a good outcome? Without probing the reasons, we lose these distinctions, which matter since clinicians tend to respect some requests but not others; female patients are more likely to be accommodated.³⁷ If female clinicians do indeed have better outcomes, then all patients would be wise to request them. But this is an unacceptable conclusion since the result would be to diminish the role of an entire gender in patient care—a socially and ethically detrimental outcome. These 2 lines of argument thus suggest that the reason someone has for requesting a certain kind of clinician is relevant to decisions about whether to honor such requests—as are the implications of concordance for the health system overall.

Finally, we consider the case of a patient who asks for a specific clinician because of concerns about physician conscientious objection. Whether health care clinicians ought to be able to conscientiously object to providing certain treatments—that is, refusing to offer them on moral grounds—has been the topic of much debate.³⁸ It is our argument that in cases in which patients would be denied a health care service because of conscientious objection, they should be accommodated if they request an alternative clinician. If a patient asks for a clinician who will perform an abortion, for example, then that request should be accommodated. Concordance of values in this instance determines whether a legitimate health care service is a priori available to a patient. Apart from ethical questions conscientious objection itself raises, we should view patient requests for a value-concordant clinician—one who will perform certain services—as reasonable.

Patient-clinician concordance when both patients and clinicians share similar values about the goals of health care and similar personal beliefs is likely to result in improved partnership in the patient-clinician relationship, and it has been linked to greater patient trust in clinicians.²³ To justify a request for concordance, however, the patient should be able to provide a reasonable explanation of the need for concordance. What constitutes “reasonableness” is a difficult question, and it is in judging the reasonableness of the request as it moves from one extreme of the continuum (a clinician’s potential conscientious objection) to fuzzier areas that these requests become ethically challenging. What we have shown is that the grounds for justifying reasonableness on the basis of evidence is limited. The grounds of reasonableness and potential benefits from value-based partnership warrant further exploration. With any benefit of concordance, like communication, whether to accommodate a concordance request means thinking about value tradeoffs within health care—an important but not overriding consideration in deciding on a patient’s clinician and care pathway.

Our argument about whether to accommodate patient requests is based on evidence of clinical benefit. Given the limited evidence of clinical benefit, we should not simply accept reasons for concordance that are grounded in claims about improved health outcomes or reduced health disparities without further probing the basis of such claims. The limited evidence supports our conclusion that concordance for the sake of health outcomes should be accommodated in few circumstances, which depend on the ability of patients to access legitimate health care—as distinct from their preferences and values, which we have not explored. While concordance might be an apparent route to increasing trust, we should focus on the harder task of improving clinician communication and patient-clinician relationships.

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HEALTH LAW

How Should Organizations Support Trainees in the Face of Patient Bias?

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Abstract

Some patients degrade, belittle, or harass clinicians and students based on their social identity characteristics, such as their race, gender, ethnicity, or religion. Some patients even refuse care. While this kind of behavior is difficult for all health care workers, it presents unique challenges for trainees. This article offers concrete protocols for supporting trainees when such patient encounters occur, including assessment, debriefing with affected staff, convening team meetings, event tracking, data collection, and initiating organizational cultural changes.

Introduction

A resident physician enters a patient's room to introduce herself, but before she can do so the patient turns to the nurse and declares, "I don't want any black doctors!" How should the health care organization respond? This question is on the minds of many, as a 2017 survey found that 59% of responding physicians had been degraded, belittled, or harassed by patients based on their social identity characteristics, such as their race, gender, sexual orientation, religion, or ethnicity.^{1,2} In addition, 47% of the surveyed physicians had a [patient request reassignment](#) because of such social identity characteristics.^{1,2} Black and Asian physicians were most likely to experience patient bias, which affected 70% of black physicians and 69% of Asian physicians.² More than simply rude or disruptive, this patient behavior can include inappropriate conduct, comments, jokes, and innuendo as well as epithets, slurs, negative stereotyping, displays of offensive materials, unwelcome physical contact or verbal abuse, and reassignment demands. While this behavior is difficult for all health care professionals, it presents unique challenges for frontline workers, particularly trainees. This article outlines the problem of patient bias and offers concrete protocols for supporting trainees based on grand rounds that I have conducted since 2016 at medical organizations throughout the United States, which have sparked a broader conversation on this issue.³

Overview of Challenges Posed by Patient Bias

Patients who engage in biased behavior pose multiple clinical challenges. Such behavior can undermine the relationship between patient and health care worker necessary to provide high quality care, disrupt team harmony and the learning environment, and take

an emotional and psychological toll.⁴ As I will explain, this behavior also has significant legal, ethical, and policy implications for health care workers' employment rights, patients' informed consent rights, and health care organizations' obligations to safeguard patient health while protecting employees from workplace discrimination.

Determining how to balance these often-competing interests presents a difficult dilemma, particularly in hospital emergency departments, which have an obligation to screen and stabilize, if necessary, all patients who seek treatment in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA).⁵ Patients also have informed consent rights, which encompass the right to refuse wanted treatment from an unwanted physician. Health care workers have employment rights, including the right to a workplace free from certain types of discrimination, such as discrimination based on race, sex, ethnicity, and religion.⁶ Health care organizations, on the other hand, not only must meet EMTALA requirements but also are obliged to safeguard the employment rights of their workers.

While this may all seem quite straight forward, determining how to weigh these conflicting rights can be difficult for health care organizations. If they accommodate a patient's wishes for a physician of a different race or ethnicity, they might be discriminating against the assigned physician and opening themselves up to legal liability.⁷ But if they don't accommodate the patient's demands, they may be violating laws against informed consent and battery by forcing the patient to be treated by an unwanted doctor without consent.⁷ And, conversely, if they don't screen and stabilize the patient, they may be liable for violating EMTALA.

I have explored elsewhere how to effectively balance all of these concerns, including the legal ramifications of accommodating hospital patients' race-based reassignment requests.⁷ And in a subsequent article, my co-authors and I offered 5 ethical guidelines to inform physicians' decision making when such cases arise: evaluating the patient's medical condition; assessing the patient's decision-making capacity; and determining the patient's reasons for the request, the physician's options for responding, and the effect on the physician.⁸ These guidelines can inform health care workers as they engage with the patient through negotiation, persuasion, and, if necessary, accommodation.

As beneficial as these guidelines are, "one-size-fits-all" policies are unlikely to provide the guidance needed to completely manage these challenging patient encounters for all health care professionals, who differ with respect to their risk of experiencing identity-based patient bias, their ability to protect themselves when these situations arise, and the legal implications of their organization's response. Trainees, for example, as frontline workers, are more likely to be targets of patient bias than attending physicians.⁹ Recent studies show that 93% of trainees have experienced disruptive patient behavior, including [racial bias](#),¹⁰ and 63% have been the object of discriminatory verbal abuse.¹¹

Fifteen percent of residents have personally experienced or witnessed mistreatment.¹² Trainees' vulnerability could be due to the frequency with which they interface with patients and their relative lack of decision-making autonomy. Attending physicians, by contrast, have more clinical autonomy and thus more options for responding, such as trading out biased patients. The increasing diversity of the trainee workforce could also contribute to trainees' heightened risk of experiencing patient bias, as at least 44% of medical students are people of color¹³ and 50% of medical students are women.¹⁴

Despite the startling statistics regarding patients' treatment of trainees, data and overwhelming anecdotal evidence show that organizations are not adequately supporting their trainees in dealing with these abusive patient encounters. Indeed, 50% of surveyed residents who experienced or witnessed patient discrimination didn't know how to respond, while 25% believed that nothing would be done if hospital leadership were notified.¹² Inaction on the part of trainees may be attributable to fear that reporting will negatively affect their evaluations or professional standing. Organizational inaction may be more complicated, due in part to uncertainty about the legal implications of responding. Residents operate in a legal limbo with respect to their rights relating to sex discrimination, for example. Some circuit courts have held that residents are both student and employees¹⁵⁻¹⁷ and are thus able to bring claims for sex discrimination under both employment⁵ and education¹⁸ antidiscrimination laws. This ability to sue offers residents access to a broad array of legal remedies, from punitive damages available under employment law to termination of the organization's federal funding under education law.

Protocols for Frontline Trainees

In light of these challenges, organizations must go beyond guidelines by developing protocols that support trainees and safeguard their rights with an eye towards crafting an appropriate future response. These protocols should include assessment, debriefing with affected staff, convening a team meeting, tracking and collecting data, and initiating organizational cultural change, if necessary. These 5 protocols constitute a point of departure for the development of an effective organizational response.

Assessment. When an incident occurs, if a supervisor is present, he or she should acknowledge the impropriety of the patient's conduct and assess whether the trainee wishes to handle the situation himself or herself. If the trainee doesn't, then the supervisor must intervene to inform the patient that the trainee is qualified to treat patients and that bigoted conduct will not be tolerated. After conferencing with the trainee, it is imperative that, whatever is decided, the supervisor model appropriate behavior and not force the trainee to accede to the patient's biased demands, as this may violate both employment and education antidiscrimination laws.

Debriefing. After the event, there should be follow-up and debriefing with the affected trainee so that he or she has an opportunity to [talk about the bias incident](#), preferably with a trusted point person. The objective is to take the trainee's difficult experience seriously, giving him or her time to vent. It's also important that supervisors and the organization not minimize the encounter and instead commit to understanding how the trainee may have experienced the harassment or rejection with an eye towards crafting a meaningful future response.

Team meeting. In addition, organizations should address the fact that bias incidents can have a corrosive effect on onlookers, who may not know what to do or how to respond. Organizations should, therefore, convene a meeting of the entire clinical team to allow members to share their experiences and discuss possible means of addressing or defusing these situations. Preparedness is imperative because prevention is impossible. Patients' biased behavior and rejections can be based on any number of identity attributes—from race and sex to disability status, religion, gender presentation, or age. Other team members, therefore, will likely experience bias or rejection at some point in their careers, and, even if they are not the object of such behavior, they will witness someone else experiencing it. Thus, the team must learn the skills necessary to handle bias incidents effectively. Another reason for a team meeting is that some staff may be unaware that their colleagues are having these experiences. Bringing these incidents to light can not only inform the team but also help prevent affected staff from internalizing the bias; since these encounters can feel like an assault, internalizing the experience is more likely to happen if staff feel alone in the experience, that they won't be supported, or that they will be accused of being overly sensitive.

Tracking and data collection. Organizational responses may also be based on collected data. A cross-disciplinary entity within the organization dedicated to providing support and assistance to patients and staff could be charged with tracking and collecting data on these bias incidents to get baseline information on how often they occur, the organization's response, the ultimate resolution of the incident, the effect on the targeted health care professional and other staff, how affected personnel are supported, and how affected personnel feel about the encounter itself and the organizational response. The cross-disciplinary entity could also make a prevalence map and identify the departments in which bias incidents are happening. These actions could all form the basis of a systematic understanding and response because more information results in better solutions.

Organizational culture change. To be most effective, organizational responses must include organizational culture change. As we have seen with the recent tide of sexual harassment allegations and the #TimesUp and #MeToo movements, many of those who brought claims worked at organizations that had sexual harassment policies.¹⁹ However, there wasn't a norm of coming forward.²⁰⁻²² These workers might have felt unsafe

reporting or that their claims wouldn't be taken seriously, or they might have feared that their claims would somehow come back to bite them by negatively affecting their career trajectories. The same can be said with respect to how health care workers, particularly trainees, might feel about reporting their treatment by patients. Even with the best policies in place, a culture of nonreporting will undermine meaningful change. Norms play an important role in shifting behavior because conduct is governed less by formal rules than by patterns of behavior that have accumulated normative power over time. Supervisors must be sensitive to this dynamic and work with the organization to create a norm of reporting and a culture of supporting staff members who have experienced discrimination.

Conclusion

Although not new, the problem of patients expressing their identity-based biases in hospitals has received significant recent media attention^{1,23-28} And while bias in the provision of health care goes both ways, as data show that physician bias towards patients remains an enduring and more common problem,²⁹⁻³⁵ relatively little has been done to address the problem of patients' discriminatory behavior towards health care professionals, which disproportionately affects people of color—particularly frontline workers, such as trainees. So long as this group continues to bear the brunt of patients' identity-based bias, the 5 proposed protocols discussed here—assessment, debriefing, team meeting, event tracking, data collection, and organizational cultural change—constitute a clinically, ethically, and legally appropriate means of supporting trainees while protecting the interests of patients and health care organizations.

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POLICY FORUM

Mayo Clinic's 5-Step Policy for Responding to Bias Incidents

Rahma M. Warsame, MD and Sharonne N. Hayes, MD

Abstract

Patient bias towards clinicians and employees in health care is common, but policy to address bias and to support staff is relatively limited. Creating a framework to address bias incidents is critical for cultivating environments that are safe for employees and patients. Mayo Clinic has created both policy to support staff and a reporting mechanism for accountability. Education, resources, and training are available and being disseminated to teach employees ways to respond to bias incidents.

Health Care Organizations and Patient Bias

Patient bias towards clinicians and employees in health care is common. In a 2017 survey that included 822 physicians, 60% of physician respondents reported that, in the past 5 years, they had experienced bias from patients on the basis of a personal characteristic—most commonly younger age, ethnicity, gender, or race but also [religion](#), weight, political views, accent, or sexual orientation.¹ Almost half of physician respondents had a patient request an alternate clinician on the basis of personal characteristics, and that request was granted 83% of the time.¹ In addition to a rise in these patient preference requests, health care professionals are increasingly subject to patients' overt discriminatory or harassing behavior.²

How health care organizations balance providing appropriate and necessary care to patients with maintaining a supportive, respectful work environment for staff can be a litmus test of organizational culture and leadership. Silence on patient bias or a "patients-first" approach can have detrimental effects on morale and leave organizations legally vulnerable. Clear policies and procedures are necessary to guide staff when discriminatory behavior occurs in the health care setting, and staff training is needed to provide awareness of resources and consequences. Typically, dozens of policies and procedures protect patients' rights and safety, but there is a paucity of literature on formal policies to address patient and visitor conduct, and even when organizations have protocols, there is often limited awareness or enforcement of them.¹ Here we highlight Mayo Clinic's policy and procedure related to patient and visitor conduct.

Policy for Reporting and Responding

History. Specific language codified into a policy to address conduct of patients that is racist, sexist, or discriminatory is a relatively new phenomenon. Mayo Clinic's Patient and Visitor Conduct Policy is not available to the public, but it went into effect internally in October 2017 after months of careful consideration of patient and staff safety and well-being; patient, employee, and organizational rights and responsibilities; and legal and ethical potential consequences. A major impetus to create this policy was a growing number of anecdotal reports of requests by patients for clinicians with or without specific personal attributes. While there was variation across practice areas, in some areas a relatively high frequency of requests was granted. Additionally, an organization-wide climate assessment found that discriminatory, biased, and harassing behavior by patients and visitors as well as requests for alternate staff disproportionately affected employees, nursing staff, and learners of color. Staff and learners reported feeling demoralized, marginalized, unsupported by their supervisory staff, and without recourse due to the lack of policy guidance or a formal reporting mechanism to address bias incidents.

The working group charged with developing the Mayo Clinic Patient and Visitor Conduct Policy, led by the second author, recognized that the problem might be more difficult to address at Mayo Clinic, where "the needs of the patient come first" is a primary value.³ Historically, there had been a strong tendency to almost automatically accede to patients' requests with little attention paid to the needs of the staff and without assessment of whether requests were just or caused distress to professionals on staff. Supervisors and attending physicians did not know how to address inappropriate comments and behaviors from patients, including microaggressions (verbal or nonverbal actions regarded as indirect, subtle, or unintentional discrimination) and requests for or comments about staff or learners based on nonclinical factors. This ignorance often led to acquiescence, silence, and failure to address the distress of an affected staff member or learner, thus leaving these individuals feeling wounded, ashamed, or otherwise distressed. Developing policy to help respond to bias incidents is critical because employees and learners are Mayo Clinic's most important resource and because Mayo hopes to mitigate risk of discrimination charges by patients who are not granted their requests and by employees and learners who feel unsupported or unsafe at work as a result of granted requests. The goal of the working group was to develop policy that would equip all staff with resources for responding to requests based upon nonmedical criteria, ensure appropriate resources are available to report and resolve bias incidents, and engage Mayo Clinic leadership to ensure employees are held accountable for responding to these bias incidents.

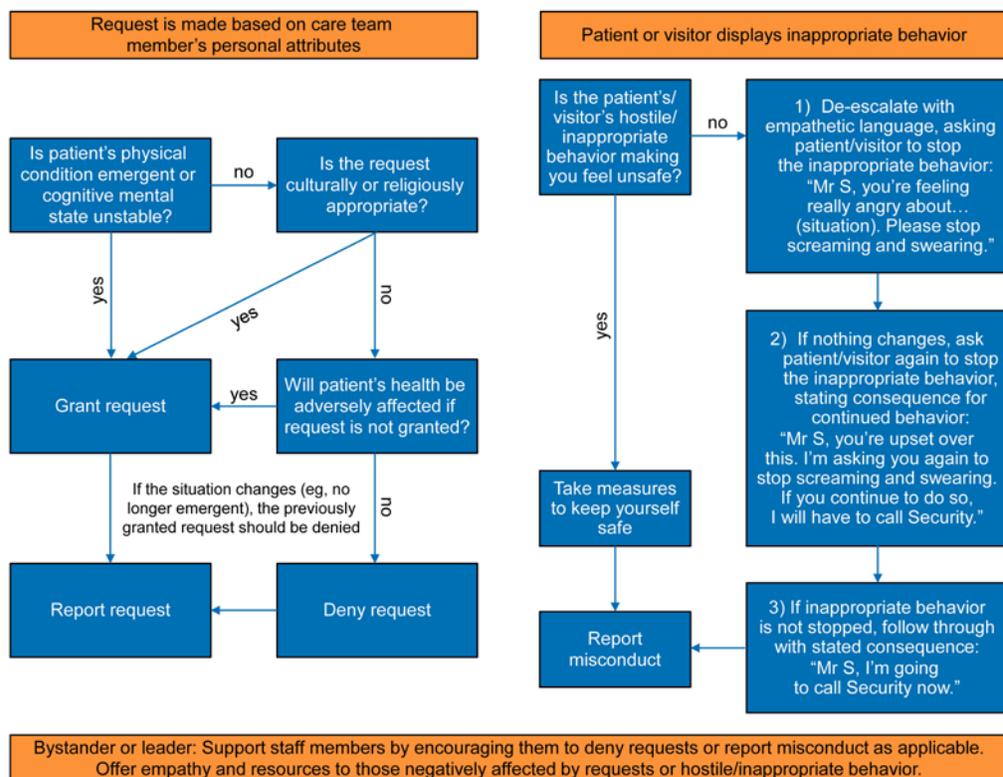
Guiding principles. A guiding principle of policy development was to balance Mayo Clinic's obligations to provide excellent and culturally appropriate care to patients and to provide a supportive and safe workplace for staff. The policy work group members were drawn

from leadership, clinicians, and students and from personnel in human relations, staff development, the Office of Diversity and Inclusion, general counsel, ethics, the Office of Patient Experience, the Integrity and Compliance Program, and the Department of Public Affairs. The scope of the final Mayo Clinic policy and procedure covers all employees—both those directly involved in patient care and support staff. Patients as well as accompanying persons were included in the policy and procedure because, in our experience, inappropriate and disruptive behavior or requests can come from family members or visitors.

The policy addresses two overarching situations: (1) requests for specific characteristics of care team members unrelated to patient care, such as race, religion, ethnicity, gender identity, or sexual orientation and (2) incidents in which patients or visitors behave in a discriminatory, harassing, or demeaning manner towards staff. The essence of the policy states that patients may not select their health care professionals based on personal characteristics with very limited exceptions that relate to potential harms to a patient if a request is not granted. In addition, if patients' or visitors' behavior to staff is derogatory or abusive, it will not be tolerated and, if persistent, could result in termination of care depending on its severity and the setting.

Exceptions narrowly defined. Deliberations about the types and application of exceptions to the new policy were nuanced and challenging. “[Zero-tolerance](#)”—such as denying all patient requests for specific preferences regarding their clinical care team—was not an option. Health care professionals have a fiduciary responsibility to address emergencies and unstable patients⁴; therefore, acuity must be considered before deciding on a response to discriminatory patient conduct.⁵ Some patients may have had prior trauma or have cultural needs that inform their requests for a different clinician, such as patients with a history of sexual assault or military veterans with posttraumatic stress disorder. Mayo Clinic's policy allows a care team to make exceptions to policy if a patient's health would be compromised by not accommodating a request. This determination is made by members of the health care team most familiar with that individual patient's clinical, cultural, religious, and social background. The working group sought to consistently apply policy; clearly communicate expectations to patients, learners, and staff; and consider exceptions in a manner that resulted in favorable outcomes for all parties (see Figure 1).

Figure 1. Algorithm for Response to Inappropriate Patient or Visitor Behavior or Request for Specific Clinician



During policy development, what required the most discussion was women patients' requests for women clinicians or other women on staff in the absence of antecedent trauma or a religious reason—that is, personal preference requests. Mayo Clinic policy maintains consistency and prohibits [choosing clinician gender](#). This deliberation was challenging, especially since many people making this request do not believe they are behaving in a discriminatory or sexist manner. While some felt that women requesting women clinicians should be an automatic exception, the decision not to include this exception in the policy was based on the view that (1) a request of this nature could adversely affect patient care if a woman clinician was not available and qualified to care for the patient, (2) it would represent a double standard (Would a male also be allowed to request a male staff member?), and (3) Mayo Clinic has an obligation to teach men and women learners to learn to care for both men and women. This policy decision helps to ensure that Mayo Clinic's learners and trainees as well as staff have equal access to patients, cases, and procedures and maintains consistent application of the policy. However, a common response to these types of requests in outpatient settings is to acknowledge a patient's request, affirm the qualifications of all staff, and make a scheduling determination based on clinical urgency, patient scheduling needs, and, secondarily, clinician gender when applicable.

Avoiding legal risk. Although not a primary reason for establishing a formal policy, protecting the organization from legal liability is also important. Patients have a right to refuse care, but this right does not outweigh employees' right to be free of discrimination. These competing rights are illustrated in the 2010 case, *Chaney v Plainfield Healthcare Center*, in which the health care organization complied with a request by a resident of a long-term care facility not to have any black nursing assistants enter the room of a white patient. The US 7th Circuit Court of Appeals ruled in favor of a black employee who sued the nursing home for violations of Title VII of the 1964 Civil Rights Act, citing that acceptance of the patient's preference created a hostile work environment.⁶ Several other organizations have been sued (and found to be in violation of civil rights laws) over employer policies allowing patient preference to dictate which rooms minority employees could enter.⁷ The upshot is this: routinely acceding to patient preferences, especially about caregivers' race or sex, exacerbates health care organizations' risk for being sued.

Communicating the policy and expectations to staff. The new policy, its rationale, and the roles that leaders and all staff must play to support its implementation—which for many was a foundational change in work process—was disseminated via a formal communication plan. The policy is included in new staff and student orientations and department chair education and has been cascaded to affected staff, along with accompanying resources appropriate to staff or learner roles.

Staff resources, training, and skill building. While policy and procedure are important, without change in organizational culture, education on the rights and resources available to employees, and a reporting mechanism for violations, there is unlikely to be a sustained change in behavior. Organizational leadership sets priorities and tone; therefore, executive endorsement of the policy, which reinforces its importance, has been critical in inspiring employees to take bigotry and misconduct seriously and in cultivating a supportive environment. Teaching employees and learners how to distinguish a patient's needs from a patient's preferences requires tactical training. Such training is ongoing and available to all staff. It includes specific content in new employee and learner orientation sessions and online learning modules and case scenarios with facilitated discussion guides. Also included in this content is the SAFER model with supportive resources (see Table).

Table. SAFER Model for Recommended Responses to Patient or Visitor Misconduct

Five Steps in SAFER Model
Step in when you observe behavior that does not align with Mayo Clinic values.
Address (the inappropriate) behavior with the patient or visitor.
Focus on Mayo Clinic values (such as respect and healing).
Explain Mayo's expectations and set boundaries with patients and visitors.
Report the incident to your supervisor and document the event using the Patient Misconduct form.

These resources are available on a dedicated website, which also includes responses to "frequently asked questions," an annotated bibliography, other training materials, videos, and scripts for varied situations and roles. The video and scripted scenarios incorporate empathic language and tips for responding to inappropriate requests; for de-escalation; for handling the angry, racist, or sexist patient; and on how to communicate denials of requests (see Figure 2).

Figure 2. Examples of Scripted Responses to Patient Preference Requests

- "Help me understand your request."
- "We are here to help you as a team. We do not change doctors/nurses/etc because of their race/ethnicity/religion/etc."
- "All Mayo Clinic team members are very qualified. Our top priority is that you receive the best care, and I know that our team members can provide that."
- "All Mayo Clinic staff are credentialed and licensed to practice in the State of _____. One of our core principles is that we treat everyone in our diverse community with respect and dignity. We are confident in _____'s character and clinical skills."
- "I would trust this physician/nurse/therapist/etc to care for my own child/family member."
- "We want to provide you with excellent care and believe that _____ is the right person to do so."
- "Mayo Clinic hires the best and brightest people to care for our patients regardless of their race, ethnicity, gender, sexual orientation, etc."

Communicating expectations to patients and visitors. Patients must be proactively informed and educated about Mayo Clinic's values, commitment to diversity, and unwillingness to tolerate patient behavior that is biased or harms staff. Ideally, this information is made

available prior to requesting an appointment. Our online “patient responsibility” policy preamble previously read, “we respect each patient’s cultural, psychosocial, spiritual and personal values, beliefs and preferences.” This preamble has since been revised to state, “We won’t grant requests for care team members based on race, religion, ethnicity, gender, sexual orientation, gender identity, language, disability status, age or any other personal attribute. If you’d like more information on our policies, contact the Office of Patient Experience.” This information is available on patient appointment portals, Mayo Clinic’s frequently asked questions webpage⁸ and at each clinical site. When patients question or challenge the policy, Mayo Clinic staff focus on conveying the core values of respect and integrity and that all team members assigned to their care are highly qualified to address their specific medical needs. When requests are unreasonable or misbehavior is persistent or egregious, steps may be taken to terminate the health care relationship utilizing a separate policy and procedure that addresses persistent abusive behavior or threats to employee safety.

Reporting events, monitoring, and review. One challenge in implementing this policy was the lack of a consistent or central reporting structure. Prior to 2017, bias incidents were reported at the discretion of the individual, work group, or department. The working group developed a central online reporting mechanism with the Integrity and Compliance Office to capture both inappropriate clinician requests—irrespective of whether they were granted—and misconduct events. Reporting is simple, can be anonymous, and includes the date of the event, the patient involved, a description of event, and whether the request was granted and why. Reporting can be done by anyone who witnessed, experienced, or is aware of a bias incident. Each reported event is reviewed within 2 business days, and additional details are obtained as needed or to clarify that the incident has been resolved and that affected staff members’ needs have been addressed. The working group retrospectively reviews all reports in order to determine the frequency and severity of bias incidents, and it assesses adherence to policy by ascertaining which requests are granted and if the nature of the incidents reported is appropriate. The presence of this transparent reporting mechanism allows detection of trends and “hot spot areas,” helps ensure that the policy is being interpreted properly, and informs needs for policy or procedural revisions and for opportunities to provide additional support or education. Creating this culture of accountability has allowed health care professionals—especially staff who are more vulnerable to discrimination—to better support each other.

Mayo Clinic Policy as One Model

A patient’s preferences can be mistaken for a patient’s needs. In a fiduciary profession, grounded in altruism, making changes that prevent granting patients their preferences can be challenging. Organizations and individuals must communicate the rationale for new policies that patients may find difficult. At Mayo Clinic, the Patient and Visitor Conduct Policy allows us to address both microaggressions and egregious behavior in a

manner that supports the rights and responsibilities of patients, staff, and the organization.

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PERSONAL NARRATIVE

One Resident's Recommendations for Responding to Unjust Patient Bias

Christian A. Pean, MD, MS and Dionne Hart, MD

Abstract

All clinicians have the right to work in environments free of discrimination. Trends such as shared decision making and tying reimbursement to patient satisfaction metrics prompt us to ask how we should respond to patient preferences that express unjust bias or prejudice. This article presents one orthopedic surgery resident physician's experience of bias incidents, suggests strategies for addressing patient discrimination, and offers patient care recommendations.

Understanding the Impact of Discrimination on Medical Trainees

In 1903, W. E. B. Dubois coined the term "behind the veil" in reference to the lived experience of black Americans existing in the shadows of society.¹ Since he wrote these words, steadfast legislative progress and activism have led to people of color in the United States achieving success that would have been unimaginable to Dubois. The pervasive legacy of racism and slavery in the United States continues, however; minorities in the United States not only face discrimination in interpersonal encounters but also endure the effects of systemic structural racism. The impact of racism and disparities in health care on patients of color is well documented in the medical literature.²⁻⁴ However, the effects of patient bias on clinicians has only recently begun to be explored in earnest. One study found that patients accounted for 40% of incidents involving resident physician mistreatment, including discrimination and bias.⁵ How physicians and surgeons of color in training encounter discrimination and should respond to prejudiced or racially biased patient preferences is not well understood.⁵ This article presents one orthopedic resident surgeon's encounters with racially biased patient preferences and suggests potential strategies for addressing such preferences.

Dilemmas in Caring for Patients Who Express Racism or Prejudice

Case 1. As a second-year resident, I visited a patient, an older white woman, the day after her total knee replacement. When I entered the patient's room, she immediately expressed skepticism of my role as a physician. Her body language was guarded, and, after I introduced myself as her physician, she suspiciously asked whether I had gone to medical school in the United States. She refused to undergo a physical exam or answer any questions pertaining to her surgery until I named the medical school from which I had graduated and provided proof. Even after I showed her my identification and

credentials, she still wasn't satisfied; I had to show her a clip of me giving the graduation commencement speech at Mount Sinai before she apologized and allowed me to continue the exam. I continued to round on her daily without further issue and never reported the incident. The experience was distressing, but it wasn't the first time I'd experienced a patient's bias against me as a health care professional.

Case 2. While on a trauma service during my intern year, I was subject to a more overt display of racism. One of our patients was a middle-aged Latino man who had been stabbed during an altercation with a black man. After we stabilized him, he acquired a systemic bloodborne infection and was being monitored on the floor. He had antagonized several staff members using expletives and was intermittently refusing treatment. After a particularly harsh exchange, his nurse, a black woman, paged me requesting I draw blood for cultures. The nurse had been unable to convince him to cooperate, and the patient, after becoming agitated and increasingly rude, asked for a physician to draw the blood instead. Upon entering the room and explaining I had arrived to take a sample of blood, he became agitated, shouted racial slurs at me, and demanded another physician. "Get me a white doctor," he exclaimed. I was taken aback, but I managed to maintain a calm demeanor. I explained that in order to take the best possible care of him, we needed to establish mutual understanding and respect. When he continued to refuse further care, I left the patient's room and returned to the surgical team's workspace. I spoke to my chief resident at the time about what to do next.

The hospital didn't have a [policy](#) in place to move forward with this patient's care in light of his demands for a physician of a particular race. He needed close medical attention, and we wondered if, by accommodating his wishes to be seen by a white physician, we were tacitly endorsing his racially problematic speech and behavior. As a team, we ultimately decided we would respect the patient's request by assigning another resident physician to care for him. We also chose to tell the patient explicitly that his prejudiced and disrespectful behavior would not be tolerated. I felt uneasy that our team's resources were being diverted to accommodate a racist patient's request, but I also knew that the alternative of limiting physician contact with him would put his well-being at risk and that further interaction with him would be uncomfortable for me. The patient ultimately left the hospital against medical advice.

Other bias incidents and their implications. These 2 interactions are not isolated. I have heard colleagues relay similarly appalling experiences. When I was a medical student, a black senior resident physician told me about the time she took care of an elderly Latino man on an inpatient service who referred to her as "my pretty slave" every day on rounds. Conversely, one of my white colleagues expressed his unease when a patient told him how nice it was to "finally have a white male doctor." It isn't clear in these situations where to turn for guidance, and resident physicians can be wary about drawing attention to such encounters because of the hierarchical nature of medical training culture.

There is an expectation in medicine that good physicians exude resilience, take care of the patient first, and tolerate personal inconvenience for the sake of advancing clinical care; to do so is widely regarded as part of a clinician's professional duty to express clinical neutrality. For physicians of color, however, this expectation can translate into being forced to bear personal humiliation in the face of racial prejudice. Most resident physicians routinely choose to sacrifice their own well-being through sleep deprivation, spending long hours in the operating room, and compartmentalizing emotions during patient encounters to provide that person with the best possible care. The tacit expectation that resident physicians unquestioningly sacrifice their dignity by tolerating discriminatory behavior from their patients in the name of clinical neutrality is unreasonable and ethically inappropriate.

Ethical Considerations in Addressing Patient Preferences

Respecting the autonomy of a patient who expresses bias or prejudice is challenging, and policy and law do not provide clear directives on how clinicians should respond. The American Medical Association *Code of Medical Ethics* supports the principle of respect for patient autonomy^{6,7}; it follows that patients should be able to select their clinician, just as physicians are not obligated to accept all prospective patients.⁸ Some patients might feel comfortable with a female physician for personal or **religious reasons**. Other patients might prefer a physician who speaks the same language.⁹ An analysis published in the *UCLA Law Review* concluded that no existing civil rights legislation bars accommodating a patient's preference for a physician of a particular race or ethnicity.¹⁰ The author of the article argued that this practice is supported by patients' rights to self-determination and informed consent.¹⁰ When a patient expresses a desire for concordance founded in racial prejudice, however, it is not readily apparent whether and to what extent a clinician's duty to treat and to respect a patient's autonomy should outweigh a clinician's right to protection from workplace discrimination. For clinicians of color who are trainees, the challenge of how to respond to unjust requests is compounded by their position of vulnerability in the medical hierarchy, the psychological toll of experiencing discrimination, and a lack of organizational resources devoted to their protection. The approach to resolving conflicts that arise from biased patient preferences and to being prepared for racial biases in patient encounters must be implemented at the institutional level with support for resident physicians.

Guidance for Organizations

When patients express bias or prejudice—which extends beyond overt refusals to accept care from a physician of color to implicit racism manifested in subtler microaggressions—an organization's obligation to create an environment for employees free from discrimination and harassment can be at odds with the goal of providing clinical care to patients. Paul-Emile et al's succinct and well-developed framework for dealing with racist patients prioritizes the urgency of a patient's condition.¹¹ An unstable patient must be treated by a readily available physician. In other words, honoring patient

preferences—including those expressing bias or prejudice—should not be priorities during emergencies; a duty to treat takes precedence even over forging a therapeutic alliance with a patient, biased or not. Physicians should firmly respond to such requests by stating that patient preferences cannot be accommodated in an emergency and that the patient’s safety and health take priority.

Once a patient is stabilized, how a physician or care team responds to such preferences should take into account the patient’s motives for making a request. Patients should be informed in a candid and respectful manner that requests motivated by bigotry are unacceptable. This goal can be accomplished by using de-escalation techniques (ie, reframing of hostile patient behavior using strategic stages of verbal engagement) and by establishing clear limits about patient speech and conduct.¹² Options for transferring a patient should be considered, and care team assignments may be negotiated at a physician’s discretion.

Guidance for Resident Physicians

Although a patient’s clinical outcome is of the utmost importance, the well-being of clinicians—particularly resident physicians—should also be acknowledged and addressed. Several articles have proposed different [protocols](#) that organizations can use to respond to both patients who express racist or discriminatory behaviors and clinicians who experience those behaviors.^{9,10} Less has been written on what resident physicians should do in these situations.^{5,13} Resident physicians of color should not feel that it is incumbent on them to navigate these challenges alone. Organizations should offer formal support and guidelines for residents who have experienced or anticipate experiencing racially prejudiced behavior from patients, and contact information for ethics consultation service should be made available. Although some articles emphasize the importance of depersonalizing such encounters,⁵ these tolerance and coping-based strategies should be seen as accompanying solid administrative stances against bigotry.

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PERSONAL NARRATIVE

PrEP and the Judgment of Prevention

Samuel Dubin

Abstract

Medicine sometimes fails to address social, economic, and political determinants of health. But how far beyond clinical encounters should intervention efforts extend? Because prevention efforts can marginalize patients by stigmatizing certain behaviors, interrogating the scope of medicine's prevention obligations is important. Additionally, it is important to distinguish clinician preferences regarding patients' personal behaviors (presumably based on clinicians' hopes for patients' positive health outcomes) from clinician biases expressed (consciously or unconsciously) about those behaviors. I illustrate the urgency of asking how far medicine should be expected to go to prevent disease by sharing how my own medical training has stoked my personal fear of acquiring HIV.

Why I Fear HIV

I fear HIV because of what it would do to my career. I'm an out, gay medical student interested in lesbian, gay, bisexual, transgender, and queer (LGBTQ) health advocacy, so the thought of getting an [HIV diagnosis](#) scares me because I get the feeling, from many different communities of which I am a part, that to get HIV would undermine my credibility and be a blow to my career. To be clear, it is not the health effects of HIV that would set me back. I have access to health care and the resources to take medications to suppress my viral load. I'm probably more likely to die riding my bike in Manhattan than from HIV. Frankly, I would rather have HIV than many other modern-day chronic diseases.

I've come to realize that my fear of HIV has to do with the social authority of medicine. By "social authority," I'm not talking about my grandmother's tacit approval of medicine as the only career she endorsed. (Heaven forbid I pursue a PhD!) Rather, what I mean by fearing medicine's social authority is that I'm more likely to be judged by colleagues for not wearing a condom than not wearing a bike helmet—but not because of statistics on comparative risks of biking and anal sex. It's because of how prevention-based medicine can create stigma by constructing "risky" behaviors as immoral under the banner of health. How could I possibly authoritatively counsel patients on their behavior, how could I help them prevent illness, if they perceived my own choices as poor and my illness as

evidence of moral failure? Who would want me as their physician or trust their health to my expertise if they knew I had HIV and thought I should've known better than to get it?

In short, according to what's typically called victim-blaming logic, those who do not take care of their health deserve the outcomes. Tobacco stigma exemplifies this logic. Isn't your first question when you hear someone has lung cancer, "Well, did they smoke"? The assumption is that people have a social duty to manage their health.

I don't endorse victim blaming; I fear it. I fear what would happen to my career if I lost credibility among my patients because they knew I had HIV. I fear having my patients hear my fear in things I say. And I fear HIV because I think many patients subscribe to a belief in self-responsibility and self-blame for illness—or at least seem to act on this belief. The perception of HIV as a moral failure would render me unqualified to prevent illness in my patients. Living with a chronic acquired health condition, on this line of thinking, makes me a moral failure and therefore an impotent clinician.

I realize that clinical encounters are not about me. I understand that most patients will probably not know my HIV status. And even if I were positive, and they did know, the extent to which they might doubt my clinical skills would certainly be variable. The thought of having my HIV status "outed" or of enduring workplace discrimination because of HIV are very real concerns. But what I dread the most—what would be most compromising to my career—is the exhausting and inevitable dissonance that preaching prevention-based medicine as a physician with HIV would force me to experience. The process of working through this fear prompted me to reflect on the nature of [HIV stigma](#) and what is expected of me as a physician. But I think it's time for medicine to do a little bit of self-reflection, too. I want medicine to ask itself: How does the social authority and cultural status of medicine create stigma and shame around notions of responsibility and health?

My Experience of Stigma

I was stigmatized by members of the health care profession when seeking to alleviate my fear of HIV by taking [pre-exposure prophylaxis](#) (PrEP), a pill that when taken daily reduces the risk of getting HIV to less than 1%.¹ I had just moved to New York City, I was single, and I had access to PrEP. But because my insurance has an enormous deductible—meaning I had to pay out of pocket until I had spent \$3000 on medications alone—PrEP was only free (using a voucher from the copay program that paid up to \$3600 annually) for 6 months. After 6 months, I would be shelling out \$150 to take a pill that, while reducing my risk of HIV, was mainly reducing my anxiety, given that I still used condoms. A price tag on the emotional risks of your sex life creates a bizarre psychology.

Ultimately, I stopped taking PrEP because the costs, financial and other, outweighed the benefits. I had made an informed decision on how to approach the health risks in my life. But to my physician, I was a risk factor. We didn't discuss the complex negotiation of

insurance issues or the pressure I felt from other gay men in New York City to have to be on PrEP. It is a privilege to have access to a physician who prescribed PrEP. But the well-meaning physician made me feel slut-shamed and stigmatized by seeing PrEP as the only option for me because of an intolerable risk of my acquiring HIV. To my physician, prevention-based medicine—"Don't let patients get a disease"—meant pushing PrEP on me. To me, this approach meant stigmatizing my gay identity as inherently risky and fostering insecurity around my identity as a medical trainee. It was then that the social authority of medicine became apparent to me.

I didn't leave my physician feeling empowered by the option of a new HIV-prevention technology. Instead, prevention-based medicine had sent the message I was risky and immoral, that acquiring HIV would be my fault.

To be a good physician, I need to prevent illness. To prevent illness, I need to probe a patient's behaviors. To do that, I need moral credibility. HIV throws a wrench in this tidy equation. These moral mechanics prompt the question: What should change in health care? My physician is not the problem. She was fulfilling her mandate of illness prevention. But this came at a cost to me, a cost that viral load and insurance bills cannot capture or quantify. I don't know how to solve this complex dilemma, but I don't see a conversation happening from which a solution will emerge.

Conversations about how far prevention-based initiatives should extend into someone's private life and the potential for prevention-based stigma must happen simultaneously. To merge these conversations requires a new framework for examining physician authority, analyzing preventative health goals, and considering everything that we know influences health. As public health shows us how many factors other than personal behavior influence health, medicine is being called upon to answer, by PrEP and other means, how much farther than personal behavior it is willing to go. It is time for medicine to tackle the blurred edges to which technology, health prevention, and public health are pushing it.

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PERSONAL NARRATIVE

Health Risks of Practicing Correctional Medicine

Dionne Hart, MD

Abstract

Correctional staff suffer high rates of posttraumatic stress disorder compared to military veterans, and the suicide rate among correctional officers is twice as high as that of both police officers and the general population and higher than that of all other professions combined. Correctional facilities' physician employees are at risk of not only burnout but also other adverse mental health effects related to working in a correctional facility. Prison reform efforts should address the needs of both inmates and clinical staff.

Burdens of Working in Correctional Health Care

How do you explain the experience of working in prison to members of the general public, whose interest in an offender ends when the flashing lights stop and the sirens are silenced? In some ways, the groupings in a prison are a visual flashback to the Civil Rights era—segregated by race, with Native Americans separated from whites, Hispanics, blacks, and Asians in dining halls, recreational units, and housing. In prisons, there are separate, self-sorted groups for various gang affiliations, white supremacists, sex offenders, and those with mental illnesses. According to the US Bureau of Justice Statistics, in 2016, there were 2 162 400 adults incarcerated in US prisons and jails.¹ As *CNN* reported, "That means for every 100 000 people residing in the United States, approximately 655 of them were behind bars."² That the United States represents about 4.4% of the world's population but houses 22% of the world's prisoners is staggering.³

When you enter a correctional facility, you are searched and your belongings are scanned. By entering, you voluntarily disconnect from the world, as you leave behind your mobile phone and almost all contact with the community. Unlike visitors, correctional staff receive a stab-proof vest, mace, a radio, and keys to internal doors. Their nasal passages are the first to recognize pungent odors from body fluids, garbage, and musty old buildings. Drawing on my 16 years of personal experience, I seek here to raise awareness of the unique health risks to correctional workers.

Correctional Staff: Demographics and Health Risks

Stereotypes abound not only about men and women who are criminally involved but also about men and women who work in these facilities. In the media, they're often depicted

as corrupt, predatory, inept, and—most recently—as political pawns.⁴ This stereotype masks the vulnerabilities of correctional staff.

Similar to the inmate population, correctional staff are predominately white men, but there are a large minority of women. According to a recent *Washington Post* article, women correctional employees represent nearly 30% of staff employed in prisons, jails, juvenile facilities, and community-based facilities.⁵ However, women correctional staff often face verbal and sexual harassment and might experience retaliation.⁵

Correctional staff—like all law enforcement officers—face constant physical risks as well as lesser-known mental health risks. For example, 34% of correctional officers suffer from posttraumatic stress disorder compared to 14% of military veterans.⁶ And the suicide rate of correctional officers is twice as high as that of police officers and the general population.^{7,8} In fact, the suicide risk for correctional officers is 39% higher than that of the general working-age population and all other professions put together.⁸⁻¹⁰ Correctional staff also have higher rates of depression and substance use.¹¹ Given these statistics, it is perhaps unsurprising that the average life expectancy of a correctional officer is 59 years compared to the national average of 75 years.¹²

Modeling Tolerance

The causes of health risks associated with correctional work are multifactorial, and every worker's story is unique. My story began more than a decade ago when I accepted a position at a prison hospital; I was young, healthy, and invested in performing my duties. Inmates were mostly appreciative. It was uncommon for a staff member or inmate to be assaulted, threatened, or harassed. That changed.

Occasionally, I would overhear black men shouting the n-word across the compound as a term of endearment to each other as they joked. I wondered why they chose to normalize a word characterized by such deep-seated pain for so many. I would hear inmates use so much profanity and slang in one sentence that it was difficult to understand even the simplest message. I would caution inmates that a judge sentenced them to prison, but the prison culture doesn't have to live in them.

Each day, I tried to model tolerance. I never withheld a greeting to an inmate covered in a swastika or confederate flag tattoos, nor considered giving special favors to someone who shared my ethnicity. I treated everyone the same. Occasionally, I would hear other staff members refer to me as an "inmate lover" when they thought I was out of hearing range, but I did not internalize their judgment. The physician workforce in the United States is only 4% black or African American,¹³ so I was well aware of my privilege to provide health care to one of the most underserved populations in the country, and I was determined to fulfill my professional duties without compromising my values.

The Challenge of Remaining Neutral

I cannot pinpoint the moment or the turning point when the prison environment began to take its toll, but it has. I recall the first time I was verbally harassed—a white inmate called me the n-word so many times in one minute that I thought he was going for a world record. He rejected my professional expertise because of the color of my skin. He expressed his preference and concluded that I was an unqualified “affirmative action hire” and that he would not permit me the opportunity to assist him. The inmate was mentally ill, so I told myself when he begins to recover and his frontal lobe function improves, he will not use such language. I informed him that often when people are ill, they feel vulnerable and seek to gain control by making derogatory comments to others, particularly those in charge of their care. I reassured him that, regardless of his derogatory comments, I would not abandon him and that he would receive the best care possible. I endured more episodes with inmates who expressed their biases, preferences, and feelings by spewing hatred, particularly when acutely mentally ill.

But soon I encountered a different type of inmate, one who used offensive language in daily intercourse solely out of disdain for my ethnicity. I began to use write-ups when I encountered this kind of insolence, hoping write-ups would help deter these behaviors. However, my reports were repeatedly ignored, dismissed (“You work in a prison”), or discarded, so I taught myself a new skill. Each time I heard the n-word, I internally replaced it with a calming word. My new means of coping solved one problem, but it also generated more questions.

Does Concordance Matter?

In a liberty-restricted setting, such as a correctional facility, how much freedom should an incarcerated person have to choose a racially concordant clinician? Since 1976, prisoners have had a constitutional right to health care.¹⁴ Does this right mean they should be allowed to choose caregivers based on racial or any other preference? In prison settings, clinician shortages limit the feasibility of honoring preferences. In addition, honoring an incarcerated patient’s preference for a clinician of a specific gender or race can unjustly undermine a nonracially concordant clinician’s authority or elevate a racially concordant clinician’s authority, perhaps for the wrong reasons.

While Americans express a value for cultural and ethnic diversity, we often shy away from discussing racial discordance in patient-clinician relationships. Yet one study of 9 white therapists found that they initiated discussions of race with black patients within the first 2 sessions to help build a therapeutic patient-clinician relationship.¹⁵ While [racial concordance](#) has been associated with improved health care experiences among minority patients,¹⁶ surveyed patients’ self-reports suggest that it does not improve outcomes,¹⁶ so it would be hard to argue that denying a patient’s concordance request constitutes a violation of a prisoner’s right. In fact, prisoners in the United States do not have a constitutional right to health care beyond the walls of their facilities and do not have a right to [request a specific course of treatment](#).¹⁷

Setting aside racial concordance, what is to be done about patient bias? An educated, outspoken woman of color is perceived by some prisoners and staff members as equally or more threatening than a prisoner. Perhaps more important are negative attitudes of patients toward clinicians; efforts to address patient bias toward clinicians like me should focus on helping clinicians build therapeutic alliance with patients. As always, it is the responsibility of all clinicians to practice medicine consistent with the American Medical Association *Code of Medical Ethics*. A physician should be dedicated to providing competent medical care with compassion and respect for human dignity and rights.¹⁸

Policy and Practice

While separated from the community by obvious barriers, correctional facilities remain a reflection of American culture, including its ethical values. In a setting so clearly influenced by race and ethnicity, correctional physicians have a unique opportunity to [lead the profession](#). Each time we are faced with patient bias, we can practice virtues of neutrality and tolerance, bedrocks of treating any high-risk population. This does not mean we should be required to do so without support from the organizations and the public we serve. Correctional physicians have the opportunity to increase the level of public awareness of the negative impacts of perceived and actual racial discrimination and race-based health disparities—and the positive impacts of intentional increased diversity in the workplace—on both patients and clinicians. And, given the number of women employed in correctional facilities, including in health care, we would be wise to promote efforts such as those of TIME'S UP Healthcare, whose mission is “to unify national efforts to bring equity, inclusion and safety to the healthcare industry” in all settings.¹⁹ What I've written here is a brief introduction to the challenges correctional staff face and a plea for federal, state, and organizational policy to address more effectively the needs of incarcerated patients and to improve the working environment of correctional workers.

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