Addressing Patient Bias and Discrimination Against Clinicians of Diverse Backgrounds

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Abstract

The duty to care for all patients is central to the health professions, but what happens when clinicians encounter patients who exhibit biased or discriminatory behaviors? While significant attention has focused on addressing clinician bias toward patients, incidents of patient bias toward clinicians also occur and are difficult to navigate.

Clinicians anecdotally describe their experiences with patient bias, prejudice, and discrimination as profoundly painful and degrading. Though this phenomenon has not been rigorously studied, it is not unreasonable to postulate that the moral distress caused by patient bias may ultimately contribute to clinician burnout. Because women and minority clinicians are more likely to be targets of patient bias, this may worsen existing disparities for these groups and increase their risk for burnout. Biased behavior may also affect patient outcomes.

Although some degree of ignoring derogatory comments is necessary to maintain professionalism and workflow, clinicians also have the right to a workplace free of mistreatment and abuse. How should clinicians reconcile the expectation to always "put patients first" with their basic right to be treated with dignity and respect? And how can health care organizations develop policies and training to mitigate the effects of these experiences?

The authors discuss the ethical dilemmas associated with responding to prejudiced patients and then present a framework for clinicians to use when directly facing or witnessing biased behavior from patients. Finally, they describe strategies to address patient bias at the institutional level.

While a neurology resident at Massachusetts General Hospital and Brigham and Women's Hospital, Dr. Altaf Saadi cared for a patient who asserted that his religion was superior to her own. As she auscultated, he pointed at her headscarf and added, "Why do you wear that thing on your head anyway?"[1]

The duty to care for all patients, regardless of beliefs or circumstance, is central to the medical profession, but Dr. Saadi's experience embodies the tension that clinicians feel taking care of biased patients. How should clinicians respond when patients exhibit biased or discriminatory behavior, and how can health care organizations develop policies and training to mitigate the effects of these experiences?

Introduction

While significant attention has focused on documenting and addressing clinician bias toward patients, incidents of patient bias toward clinicians also occur and are difficult to navigate.[2,3] In a recent survey of 822 U.S. physicians, 59% reported having heard offensive remarks from patients about their age, gender, ethnicity, race, weight, or other personal characteristics in the past 5 years and 47% had patients request a different physician.[4] These incidents begin early in training: One study of 242 family medicine residents revealed that patients accounted for 35% of the intimidation, harassment, and discrimination experienced by trainees.[5]

Biased patient behavior can manifest in various ways in the clinical setting. In a qualitative study of 50 trainees and physicians, participants reported incidents of patient bias that ranged from explicit rejection of care and prejudiced epithets to inappropriate compliments, flirtatious comments, and belittling jokes reflecting ethnic stereotypes.[6] It is important to make the distinction between bias, prejudice, and discrimination. Individuals are often biased against others outside their social group (and sometimes against those in their social group), and prejudice refers to biased thinking, while discrimination refers to biased actions against a group of people.[7]

Clinicians anecdotally describe their experiences with patient bias, prejudice, and discrimination as profoundly painful and degrading.[8] For example, after a patient refused to see Dr. Cornelia Wieman because she was Indigenous, she recalls feeling humiliated and helpless, eventually calling for another physician because she "didn't feel like [she] had a choice."[9] Similarly, Dr. Esther Choo, an Asian American emergency room physician in Oregon, recounts her experience "cycling through disbelief, shame, and anger" after patients refused her care exclusively based on her race.[10]

Though this phenomenon has not been rigorously studied, it is not unreasonable to postulate that the moral distress caused by patient bias may ultimately contribute to clinician burnout.[8,11] This has particular implications for minority patients. Because minority clinicians are more likely to experience patient bias, this may increase their risk for burnout and lead to fewer minority clinicians in medical practice. Research suggests that racial and ethnic minority patients might achieve better outcomes when cared for by minority clinicians, so the alienation of minority clinicians by biased patients may actually worsen outcomes for minority patients.[12]

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The ethical and legal obligations of the medical profession make it challenging for clinicians to confront patients' prejudiced remarks and behavior. There is an implicit expectation that clinicians must care for patients no matter their behavior.[6,13] Although some degree of ignoring and "rising above" derogatory comments is necessary to maintain professionalism and workflow, clinicians also have the right to a workplace free of mistreatment and abuse. How should clinicians reconcile the expectation to always "put patients first" with their basic right to be treated with dignity and respect?

During health professions education and training, clinicians receive little instruction on answering this question; instead, they learn to filter their own responses to ensure patients feel safe and secure.[14] In one study of pediatric residents, 50% indicated not knowing how to respond to mistreatment by patients and their families.[15] Moreover, few health care organizations have clear policies and procedures to guide staff in responding to incidents of biased patient behavior.[8] As the clinical workforce becomes increasingly diverse, it is possible that such interactions may occur more frequently. Medical schools and health care organizations should therefore strive to create an environment that respects the diversity of both patients and clinicians.

Patient Bias and Discrimination Against Clinicians

Despite slow progress, the U.S. health care workforce is becoming increasingly diverse: Women now outnumber men in medical school, 19% of registered nurses are from minority groups historically underrepresented in the health care workforce, and 28% of practicing physicians are foreign-born.[16,17] As patients encounter clinicians whose identity may be discordant with their personal notion of a trustworthy, competent clinician, some may reject or demean them based on their personal characteristics. Although systematically collected data on the prevalence of these interactions is lacking, anecdotes from individual clinicians and reports from online surveys suggest most health care professionals will experience patient bias over the course of their careers.[6]

The immediate and downstream impacts of bias and discrimination are especially damaging in the health care environment, where they can compromise the patient–clinician relationship and directly influence the quality of care provided. In this section, we describe patients' discriminatory behaviors and their effects.

Patients' biases and discriminatory behaviors

Patient bias can take many forms in the clinical setting, and this variation emphasizes the need for teaching clinicians what behaviors and attitudes constitute bias and discrimination. In one study of physician and trainee experiences with patient bias, the authors interviewed 50 hospitalist attending physicians, internal medicine residents, and medical students to understand how clinicians react and respond to these incidents. They found that types of demeaning behaviors by patients included: (1) explicit refusal of care, (2) explicit or socially based remarks, (3) questioning clinician role, (4) nonverbal disrespect, (5) jokes or stereotypes, (6) assertive inquiry into participant's background, and (7) contextually inappropriate compliments or flirtatious remarks.[6]

Patients' biases and discriminatory behaviors can target a broad range of personal characteristics associated with clinicians. These include, but are not limited to, gender, age, ethnicity or national origin, race, weight, accent, political views, religion, medical education from outside the United States, and sexual orientation.[4] Further, patient bias affects all health care professionals. WebMD/Medscape and STAT, both online publishers of news and information related to health and well-being, conducted an online survey of 1,186 health care professionals drawn from a random sample of Medscape members. They found 59% of surveyed physicians, 53% of nurses, 55% of nurse practitioners, and 57% of physician assistants reported having heard prejudiced remarks by patients.[4]

Some groups are targeted more often than others. Compared with physicians, nurses and ancillary staff spend more time with patients and receive less protection from organizational policies regarding patient requests.[14,18] In 2013, Tonya Battle, a Black nurse at Hurley Medical Center, sued the hospital for discriminating based on race and conceding to a White swastika-tattooed father who demanded that no Black nurses care for his newborn. In a classic example of the medical culture of accommodation, the hospital posted a notice prohibiting African American nurses from caring for or touching the baby.[19] This case, and the dozens of others that followed, revealed the insidious effects of bias and discrimination on those at the frontlines of patient care.

Nationally, it is estimated that 25% of nurses experience mistreatment by patients each year, but many fail to report these episodes.[20] The reasons are complex and include (1) power differentials that situate nurses as having less authority and knowledge than physicians, (2) hospital management reluctant to hold patients responsible for inappropriate conduct, and (3) learned helplessness that patient mistreatment is simply part of the job and must be tolerated.[21,22] For these reasons, it is crucial that all health professionals, especially nurses, aides, and other staff at a higher risk of exposure, benefit from initiatives to protect staff from discriminatory patients.

In addition, women and clinicians from minority groups may bear a greater burden of patient bias and discrimination. Research shows that female physicians are more likely to hear prejudiced comments and Black physicians report regular instances of racist treatment from patients.[4,23–25] In an essay about racism shifting the power dynamic in medicine, Dr. Nwando Olayiwola, a Black female physician at San Francisco General Hospital, recounts her experience caring for a patient who explicitly stated, "You didn't tell me I was going to see a Black doctor. And not just a Black doctor, but a Black woman!" Though Dr. Olayiwola had become more resilient to these kinds of situations—as a resident, she had cared for a patient who said, "All Black, Hispanic, Asian, and Jewish doctors should be burned alive," and another who said she would "rather die than be touched by a filthy Black doctor"—this patient's remarks still left her feeling powerless and embarrassed.[26]

Effects of patient bias and discrimination

Patient bias and discrimination may impact clinician well-being in the short and long terms. Studies conducted in the general population have shown that individuals who are targets of racism, sexism, homophobia, and other forms of prejudice have higher rates of anxiety, depression, high blood pressure, and cardiac disease.[27] In addition, the emotional burden of caring for a biased patient can be substantial and is associated with symptoms of psychological decline and professional burnout, such as emotional exhaustion, fear, cynicism, and self-doubt. Research shows these emotions linger long after the inciting event and can generate a profound sense of invalidation and isolation among health care professionals.[28–30] In addition, they may lead to imposter syndrome, defined by persistent feelings of self-doubt and an inability to internalize one's accomplishments and abilities. Imposter syndrome is already widespread in medicine—studies have found evidence of imposter syndrome among clinicians at all stages of their careers—and exposure to biased patient behavior may worsen these feelings.[31,32] At a time when clinician well-being and burnout remain at the forefront of national discourse, medical schools and health care organizations that champion diversity must strive to address the emotional burden associated with caring for biased patients.

The emotional toll of discriminatory patient behaviors may also affect clinicians' learning and practice. Some trainees report avoiding rotations and clinical sites where encounters with biased patients are common, while others note a decreased ability to focus on learning, training, and developing into a better clinician.[6] Consequently, repeated encounters with biased patients may impact trainees' professional development and eventual career choices, though this has not been explicitly studied.

Biased behavior may also affect patient outcomes. Many clinicians believe they can rise above the negative emotions conjured by biased patient behavior, but anecdotes from individual clinicians suggest that they may feel reluctant to spend extra time with patients who broadcast bigoted views.[27] Given that decreased time spent with patients is associated with decreased patient satisfaction, suboptimal visit content, and higher rates of inappropriate prescribing, we surmise that bias may impact the quality of care that patients receive.[33]

Lastly, the fact that women and minority clinicians are most often the targets of biased patient behavior raises an important question: can bias worsen existing disparities for these groups? This is an area of active investigation, and it is hypothesized that women and minority clinicians may receive lower patient satisfaction scores partly due to increased exposure to bias and, because clinician reimbursement is associated with patient satisfaction, lower pay. Patient satisfaction scores can also influence whether—and which—clinicians are offered opportunities for career advancement and leadership.[24]

Clinician Response to Patient Bias and Discrimination

Incidents of patient bias and discrimination, such as patients' requests for reassignment based on clinicians' personal characteristics, present a complex business, legal, and ethical dilemma. Because this type of mistreatment cannot be prevented, effective preparation is crucial. In these situations, clinicians are responsible for balancing patient preferences with the duty to treat and demands of justice and nonmaleficence.[34] In this section, we begin with an overview of the rights of patients and clinicians related to situations where bias may arise. We then discuss the ethical principles that clinicians and institutions must consider when responding to patient bias and describe barriers to responding. Finally, we present a framework for clinicians to use when facing or witnessing patient bias.

Rights of patients and clinicians

Both patients and clinicians have professional and legal rights that should be balanced within the practical realm of providing effective care for all patients. Informed consent rules and common law grant competent patients the right to refuse medical care, including treatment provided by an unwanted clinician.[35]

The American Medical Association (AMA) Code of Ethics confirms that patients have the right to choose their clinicians.[36] In addition, the Emergency Medical Treatment and Active Labor Act (EMTALA) is a federal law that requires hospitals to stabilize and treat any patient that comes to the emergency department or, with patient consent, arrange for a transfer to a more suitable facility.[37]

The employment rights of clinicians are slightly more complex. According to Title VII of the 1964 Civil Rights Act, employees of health care organizations have the right to a workplace free of discrimination on the basis of sex, race, color, national origin, and religion.[38] However, many physicians are independent contractors rather than hospital employees and are not covered by Title VII. Thus, while nurses and nursing assistants have successfully sued their employers who required employees to accede to a patient's bigoted demands, physicians have not brought forth such lawsuits because they are often not protected by Title VII.[8] This ambiguity makes it challenging to use legal standards to distinguish between patient demands that should be accommodated and those that should be denied.

Ethical dilemma presented by patient bias and discrimination

When confronting patient bias, clinicians must balance patient autonomy with the ethical principles of justice and nonmaleficence. Patients are entitled to their individual beliefs and opinions, but when patients express views rooted in bias and bigotry, how should clinicians proceed?

For example, consider the experience of Dr. Bernard Sussman, a Jewish internist caring for Mr. W. During one visit, Mr. W revealed that he had served in the armed forces of Nazi Germany in Hitler's personal honor guard. Pressed further, he grew angry, claiming that the "Jews were responsible for everything that happened to them." Dr. Sussman, whose moral consciousness was shaped by his family's history of persecution during World War II, was left stunned. Though he completed the appointment, Dr. Sussman grew increasingly distant in Mr. W's subsequent visits—he did not examine him or evaluate potentially concerning symptoms, treated him over

the telephone whenever possible, and prescribed medications without seeing or speaking to him. Dr. Sussman struggled to reconcile his patient's beliefs with his own integrity, and upon realizing that their patient–doctor relationship had been irreversibly damaged, informed Mr. W that he needed to find another physician.[39]

Although "first, do no harm" is the moral compass that guides clinicians in their interactions with patients, we contend that nonmaleficence should apply for both patients and clinicians.[40] In this situation, Mr. W's beliefs conflicted with Dr. Sussman's personal identity and impeded his ability to deliver excellent medical care.[36] Thus, when considering possible responses to a prejudiced patient, clinicians must weigh the primacy of patient preferences against their own values, feelings, and consequent ability to provide high-quality, patient-centered care.[34] While the medical profession mandates clinicians to subordinate self-interests to patients' best interests, no ethical duty is absolute.

At the same time, we note that terminating a patient–clinician relationship is not the right solution in most cases. The nature of the patient–clinician relationship means clinicians have a professional and ethical obligation to ensure all patients receive the best care possible. The clinician has knowledge, influence, and power in the relationship, which confers special responsibilities. During an encounter with a biased patient, it can be challenging to see them as vulnerable, but their vulnerability would only be compounded without a clinician's help.[41] As such, we should be careful not to jump to conclusions and instead pursue a more deliberate, thoughtful approach consistent with our commitment to patient care.

Challenges of responding to patient bias and discrimination

Since most health care organizations provide little guidance on responding to patient bias, there is significant variability in how clinicians respond. Some may choose to ignore hurtful comments or accommodate requests for reassignment to avoid confrontation with biased patients.[6] Others may elect to ignore or accommodate behavior due to the potential consequences associated with responding (e.g., poor grades, professional evaluations). However, allowing the behavior to continue unfettered may (1) signal to the patient that such behavior is acceptable and (2) instill a mindset, especially among trainees, that these incidents are simply part of the job. It also raises the question of whether clinicians are tacitly endorsing the patient's behavior.

Other clinicians may react differently. For example, in an incident at the Brigham and Women's Hospital, an Indian American resident (S.H.J., when he was a trainee) saw a patient who angrily shouted, "You people are so incompetent … why don't you go back to India?" On instinct, the resident responded with, "Why don't you leave our [expletive] hospital?" and after leaving the room in a cold sweat, absolved himself of future clinical interactions with the patient.[42] This example shows that responding to patient bias is hard and can drive clinicians to say or do things they normally would not. The resident is emotional, but nonetheless, his response was not professional and could have led to punitive action against him. This case illustrates the need for additional training and education materials to help clinicians learn to better handle these situations and avoid saying or doing something inappropriate themselves. The current lack of training on what constitutes biased behavior and appropriate responses is a key barrier to responding professionally in these situations.

There are other barriers that also make it challenging for clinicians to respond to biased patient behavior. Some clinicians prioritize the importance of building a lasting patient–clinician relationship and excuse derogatory remarks from patients with impaired cognition, such as mentally ill or intoxicated patients. Many are unaware of institutional policies regarding discriminatory patients and fear that responding might compromise professional evaluations. Finally, a perceived lack of support from colleagues, supervisors, or institutions can prevent clinicians from addressing biased behavior with patients.[6] These barriers underscore the benefits of integrating training on biased patients into clinical curricula and revamping organizational policies and protocols around patient discrimination.

There are also barriers that make it challenging for institutions to respond to biased patients. Although hospitals and health systems should strive to help clinicians navigate issues of patient bias, the reality is that no policy, recommendation, or ethical guidance can anticipate every possible situation. In addition, we operate in a resource-limited health care system that can prevent us from following a prescribed course of action. For example, if a patient refuses care from a Black nurse in a rural clinic, but there is no other nurse available, we have a greater obligation to make the relationship work. Here, we might try a more exhaustive array of negotiation and persuasion tactics since we cannot simply transfer care to another provider. For example, clinicians could explain the impact of the patient's refusal on their health or ask the patient to accept care until an alternative solution is found. In these cases, the legal right that patients have to choose their own clinician can make it more challenging to refute requests for reassignment.[34]

Framework for responding to patient requests for clinician reassignment

How should we respond to a patient's refusal of care from a specific clinician based on sex, race, sexual orientation, or other characteristic unrelated to patient care? As an example, consider a patient's race-based request for reassignment. As per the AMA Code of Ethics and an analysis of race-based accommodation by the University of California Los Angeles Law Review, accommodating patient preference for clinicians of a specific race or ethnicity appears to be consistent with ethical principles of informed consent and autonomy.[35,36] However, clinicians also have the right to a workplace free of discrimination (although Title VII may not apply, as explained earlier), and these rights must be balanced with patients' rights before race-based reassignment requests are accommodated.[38] Some also contend that granting a patient's bigoted request for reassignment is analogous to institutionalized racism.[43]

In their landmark *New England Journal of Medicine* paper on responding to patients' race-based requests for reassignment, Paul-Emile et al recommended making a decision based on: the patient's medical condition, decision-making capacity, options for responding, reasons for the

request, and effect on the physician.[8] In our framework, we build upon the tenets espoused by Paul-Emile et al.

We believe there are reasonable motives for reassignment and patients are not required to feel equally comfortable with all clinicians.[34] This does not mean patients are bigoted—a Black patient may simply feel more comfortable being cared for by a Black physician. The role of clinicians involves understanding the factors that contribute to this comfort and determining whether these factors are rooted in bigotry. One strategy is to ask the patient about the reasoning behind their request. A deeper investigation of the reasons underlying a Black patient's preference for a Black physician may reveal an understandable distrust of health care professionals stemming from the medical establishment's historical exploitation of Black patients (e.g., the Tuskegee experiment, Henrietta Lacks, the "father of gynecology" who experimented on enslaved Black women).[44,45] For these reasons, we are inclined to accommodate the patient's request.

In contrast, consider an example from the *AMA Journal of Ethics* in which a Black patient requests a Black physician instead of Dr. Chen, her current physician who is East Asian, after stating "Dr. Chen is good, but sometimes I can barely even understand what he's saying. You know? The accent? I mean, everywhere you go now, it's immigrants. Sometimes you just want someone who looks like you, you know?"[34] Now the situation becomes more complicated. Are the patient's beliefs motivated by xenophobia or grounded in an increased comfort with Black physicians and difficulty communicating with Dr. Chen? In this case, further information is needed to determine why the patient holds these views and whether the patient's health will be adversely affected if her request is not granted.

There is no one-size-fits-all answer for responding to patients' requests for specific clinicians, and it is impossible to anticipate every possible situation, but we believe that culturally or religiously appropriate requests should be accommodated. This includes religious dictates (e.g., a Muslim woman requesting a female physician), gender preferences (e.g., a woman requesting a female physician for a gynecological exam), and language barriers (e.g., a Spanish-speaking patient requesting a Spanish-speaking physician). In these cases, patient–clinician concordance is known to be associated with greater comprehension, trust, and satisfaction.[46]

Even if requests are not considered culturally or religiously appropriate, there are exceptions for which accommodation may be ethically justifiable. For example, some patients may have prior experiences with trauma that directly inform their requests for a different clinician. This includes victims of sexual assault or veterans with posttraumatic stress disorder who refuse treatment from a clinician of the same ethnic background as a former enemy combatant. In addition, if the patient's condition is emergent or cognition is impaired, we would err on the side of granting the patient's request.[8] In all of these cases, accommodation is justified because there is a real possibility the patient's health will be affected if their request is denied.

Requests motivated by bigotry are far less deserving of accommodation. In these cases, clinicians can negotiate with the patient and attempt to establish mutually acceptable conditions for providing care. They can also try to persuade the patient, perhaps with the help of family members, to accept care. If these approaches are not effective and the patient continues to persist in their bigoted demand for reassignment, clinicians can consider transferring the patient's care to another provider in the same clinic (resources permitting) or to a different clinic. If the patient continues rejecting care and their health is not at risk, administrators can intervene and inform them of their right to seek care elsewhere.

When weighing these considerations, it is important to understand and respect the effect on the clinician. Expressions of patients' racial preferences can degrade the therapeutic alliance, defined as the affective relationship between patients and clinicians, and clinicians should feel free to express their discomfort to patients when such requests are made.[47] When a patient's views interfere with the clinician's well-being or preclude the clinician from delivering good medical care, it may be best to reassign the patient.

Framework for responding to biased patient behavior

As a cardiology resident at the Mayo Clinic, Dr. Sharonne Hayes encountered male patients who commented, "You're too beautiful to be a doctor," and then proceeded to describe, in detail, what sexual acts they wanted to engage in with her. And Dr. Kali Cyrus, a psychiatrist at Sibley Memorial Hospital, supervised a female trainee who reported that a male patient grabbed her crotch during a physical exam.[48]

Clinician safety and well-being are paramount when confronting patients who demean, harass, or mistreat them.[48–50] Thus, the central question when responding to biased patient behavior is, "Do you feel safe caring for this patient?" If a clinician feels unsafe, it is their right to exit the patient encounter and seek help from a colleague or supervisor, report the incident to the appropriate organizational leadership, and consider transferring care.

Concurrently, clinicians must assess the patient's medical condition and determine whether there is time to safely transfer care. In an emergency situation, clinicians must weigh personal safety against the ethical and legal obligation to treat. EMTALA protects patients presenting with an emergency condition, so if other clinicians are unavailable or time is limited, it may become necessary for clinicians to treat and stabilize the patient before making alternative arrangements.[37]

If the clinician feels safe and the patient is stable, they should assess the patient's reasons for biased behavior. Though we do not condone them, there are legitimate reasons for why patients may direct derogatory comments at clinicians.[51] For example, patients with impaired cognition, such as those with dementia or traumatic brain injury, may suffer from reduced decision-making capacity and are generally not held responsible for biased or discriminatory behaviors.[8] Or, patients may have experienced past traumas that affect how they perceive and react to certain groups. For example, we may be sympathetic toward a woman who begins cursing at a male physician because his touch conjures painful memories from her past history of sexual assault.

Intentionality is a useful heuristic for determining whether a patient's biased behavior should be tolerated: Do they convey an intent to hurt or shame the targeted clinician? When making this determination, clinicians should factor in information about the patient as a person, their attitudes, and their usual style of communicating with others. When biased behavior does not meet criteria for intentionality, tolerating or accommodating this behavior may be appropriate.

If biased patient behavior is rooted in bigotry, clinicians should respond to hurtful comments or actions. They could begin by acknowledging how the patient's inappropriate behavior made them feel (e.g., "It makes me feel uncomfortable when you comment on my appearance") and asking them to please stop, since such behavior is not tolerated as per organizational policy. Clinicians can also redirect the conversation to focus on the medical problems at hand and try to use empathetic language to deescalate a tense situation.[52]

If the patient relents, then clinicians can continue cultivating a therapeutic alliance. Clinicians can strive to build rapport and explore patient biases without the intention of changing them or recognize that patients' comments are often motivated by fear and anxiety and should therefore not be taken personally.[15] Before proceeding with caring for a biased patient, clinicians must evaluate their own values and feelings and consider their ability to forge a therapeutic alliance rooted in trust.[34] Although professionalism requires clinicians to anticipate a broad range of human behavior in response to illness, it does not require that clinicians acquiesce to attacks on their self-worth, dignity, and identity.[53]

If the patient persists in their biased views, clinicians can consider other alternatives. Assuming availability of other qualified clinicians, the patient's care could be transferred to another clinician. Or, in severe cases, administrators can inform the patient of their right to seek care elsewhere. Given the impact on a patient's health, this approach should only be considered when all other avenues for negotiation, persuasion, and compromise have been sufficiently exhausted.

Following an encounter with a biased patient, clinicians should inform hospital administration and training supervisors. Depending on the severity of the incident, clinicians can also consider documenting the interaction in the patient's chart. Though documenting the interaction can help protect other clinicians from harm, it may also impact the quality of care the patient receives in the future. It can be difficult to distinguish between incidents that should and should not be documented, but we recommend documenting all incidents deemed to be rooted in bigotry.

If care is ultimately transferred to another clinician, handoffs should incorporate a formal ethics consultation. If an ethics consult is not available, then clinicians should seek counsel from other health professionals and engage in a balanced discussion of whether a patient's behavior warrants transferring care, and the pros and cons of doing so. These steps are necessary to ensure a safe learning and working environment for trainees and clinicians. In addition, we recommend that biased patient behavior be discussed during team debriefings soon after the incident. Doing so can emphasize the importance of clinician safety, allow for critical reflection, and transform a painful experience into an opportunity for professional growth and learning.

Responses to patient bias directed at trainees. As a medical student at the University of Virginia School of Medicine, Dr. Jennifer Okwerekwu was on her internal medicine rotation when a patient called her "colored girl" 3 times in front of the attending physician. The attending did not correct the patient or address the incident with Dr. Okwerekwu privately, leaving her wondering if she too thought of her as a "colored girl." And because Dr. Okwerekwu worried that calling attention to the incident might jeopardize her grades or evaluations, she ultimately decided to stay silent.[54]

Trainees are particularly vulnerable to patient bias. A recent study showed that 15% of pediatric residents at an academic medical institution have personally experienced or witnessed mistreatment, and of these instances, 67% involved mistreatment by patients and families.[15,55] The prevalence of patient mistreatment of trainees is complicated by their position in the medical hierarchy. Like Dr. Okwerekwu, trainees may be wary about drawing attention to encounters with biased patients due to the risk of being perceived as weak, vulnerable, or flawed by supervisors, and the potential repercussions on grades or professional evaluations.[56]

While our recommendations for responding to patient requests for clinician reassignment and biased patient behavior apply to trainees, this leaves the question of how supervisors and peers should react in such situations. Because trainees generally have little decision-making authority to protect themselves, it is crucial that supervisors and peers step in when needed.[56]

In light of these challenges, we propose the following strategies for supervisors and peers to address patient bias directed against trainees. If necessary, trainees should separate themselves from a biased encounter (and should expect support from supervisors), but we believe that terminating an uncomfortable patient encounter should not be a trainee's immediate response, as vital learning opportunities could be foregone.

Supervisor intervention. Supervisors should strive to set expectations and discuss protocols for responding to biased patients at the start of their relationships with trainees, including when a trainee might wish to handle a situation independently. If a supervisor observes patient bias against a trainee and discerns that the trainee does not wish to handle the situation independently, they should intervene.

Supervisors can begin by acknowledging the inappropriateness of the patient's comments and describe their impact on the trainee (e.g., "I don't think you meant to be hurtful, but your comments made us feel uncomfortable"). In cases of requests for reassignment, they can proceed to reaffirm the trainee's role and clinical competence (e.g., "She is a well-qualified medical student, and I am confident we will take good care of you together"). The supervisor can also reiterate their goals to deliver the best possible care and strive for comfortable patient–clinician relationships. Finally, supervisors can explain that such comments are not tolerated as per organizational policy.

If the patient persists in their behavior, then alternative options can be considered. For example, the trainee could be recused from caring for the patient and the patient's care could be transferred to another clinician. It is essential that supervisors are trained in managing these types of situations. Research shows that trainees who have seen faculty members model appropriate responses to biased patients are better prepared to manage similar situations when they arise in the future.[57]

Peer intervention. If a trainee observes patient bias against another trainee, they can consider intervening or alerting supervisors. Because it can be challenging for trainees to understand when and how to intervene, training programs should establish guidelines around peer intervention. Demeaning patients can reinforce trainees' feelings of invisibility in the clinical workplace, so it is crucial for peers to show support and acknowledge the impropriety of such behavior.[58]

Debriefing. Research has consistently demonstrated the value of purposeful reflection in processing and learning from emotionally challenging clinical encounters.[59,60] Following the event, supervisors should debrief with the affected trainee and provide them with an opportunity to talk about the experience in a safe and nonjudgmental environment. It is important that supervisors not minimize the trainee's experiences and guide them in crafting a meaningful future response. To facilitate learning, supervisors can empower students to brainstorm and discuss alternative responses to biased patients and families.

Nontargeted bystander responses to patient bias. Nontargeted bystanders frequently experience moral distress and uncertainty regarding how to protect colleagues.[6] Thus, institutional guidance for navigating biased patient encounters would benefit from training on bystander intervention. Drawing from examples of bystander intervention to combat public harassment, we present 4 methods that nontargeted bystanders can use to support colleagues experiencing patient bias.

Direct or indirect intervention. Before deciding to intervene and directly respond to a biased patient, clinicians must assess their personal safety and the safety of the targeted clinician, the likelihood that the situation will escalate, and whether the targeted clinician desires assistance. When intervening, clinicians should focus on assisting the targeted clinician and refrain from engaging in dialogue or debate with discriminatory patients. Examples of phrases to use when intervening include, "I'm sure you didn't mean to be hurtful, but that is inappropriate, disrespectful, etc."[61,62]

In situations with particularly inflammatory patients, indirect intervention may be the more suitable approach for assisting colleagues. An indirect approach to deescalating the situation may involve distraction (e.g., interrupting the encounter to speak with the targeted clinician about an unrelated topic) or asking for help from supervisors or colleagues.[62] These approaches can provide targeted clinicians with an opportunity to exit a threatening situation.

These approaches should be used with caution. In many cases, a targeted clinician may not want assistance and might prefer to manage the situation themselves. There is also the possibility that intervention can inadvertently cause a debate or damage the targeted clinician's relationship with the patient. In light of this concern, organizations should create structured opportunities for all trainees and supervisors to think about, discuss, and establish consensus around best practices before these situations arise in real life.

Check in and offer support. Following an encounter with a biased patient, bystanders can check in with targeted colleagues, acknowledge what happened, and offer empathy and support. Sharing past experiences with biased patients can be particularly useful. Clinicians, especially trainees, report that hearing similar accounts from their peers reduces feelings of isolation and self-doubt about their professionalism.[57] In addition, because institutional guidance regarding discriminatory patient behavior is lacking, bystanders can share resources to help colleagues process or report the incident. Such resources include brochures or online resources on patient bias, information on institutional policies, and contact information for institutional offices or faculty champions equipped to deal with these incidents.

*Convene team meeting***.** A team meeting can allow clinicians to care for each other, share experiences, and discuss options for navigating and responding to patient bias. This can help targeted clinicians feel visible and supported. A team meeting may help prevent clinicians from internalizing the damaging impacts of bias and discrimination by demonstrating that others have experienced similar incidents out of no fault of their own. In addition, bringing these incidents to light can help nonaffected team members develop the skills necessary to manage biased patients in the future.[57] When convening team meetings, administrators need to make sure that clinicians are aware of and understand reporting laws. In some states, if an employee confides in another employee regarding abuse in the workplace, they are required to report the incident to the institution's Title IX officer.[63]

Strategies for Addressing Patient Bias at the Institutional Level

Institutions have an ethical obligation to ensure the safety and well-being of clinicians. As such, they must develop comprehensive policies and procedures around patient bias. Concurrently, patient bias must be integrated into health professions education. In this section, we describe specific strategies for addressing patient bias through patient and clinician education, trainee development, and organizational policy change. To ensure our recommendations are consistent with patient rights, we conclude by providing a legal perspective on the limits to addressing patient bias.

Guidelines for patients

While most institutions encourage a culture of respect through slogans and their website, few have antidiscrimination policies for patients. We recommend that institutions strive to proactively communicate expectations around values, commitment to diversity, and intolerance for patient conduct that is biased or harms staff. This information should be readily available and provided to patients before requesting an appointment.[52] Some organizations have begun to address this topic. For example, the Mayo Clinic recently revised its "patient responsibility" policy 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."[64] This policy is available at each clinical site, patient appointment portals, and the frequently asked questions webpage. A separate policy delineates the consequences of abusive behavior or threats to employee safety.[52]

We recommend that all health care organizations develop similar guidelines for patient conduct. Doing so can emphasize the organization's commitment to cultivating a safe, respectful, and supportive workplace for staff. Organization leadership should play an active role in creating and enforcing these guidelines since executive endorsement is crucial to their success. Concurrently, institutions must define the consequences of violating these guidelines.[62] A "zero tolerance" policy is insufficient—the consequences of violation must be considered alongside the duty to provide care.

Education for clinicians and trainees

Changes to organizational policies should be followed by efforts to educate clinicians on (1) their rights and responsibilities as caregivers and employees and (2) how to respond when facing or witnessing discriminatory patient behavior. This training should be longitudinal and mandatory for all staff. At the Mayo Clinic, content on managing biased patients is included in new employee and trainee orientation sessions, online learning modules, and case scenarios.[64] Similarly, a team of psychiatrists at the Yale School of Medicine runs 90-minute workshops to help faculty physicians manage patient mistreatment of residents and medical students. Their approach is summarized by the acronym ERASE: Expect that mistreatment will occur, Recognize mistreatment when it does occur, Address the situation in real time, Support learner after the incident, Establish and encourage a positive culture.[48,65]

Drawing from these examples, we propose that education for clinicians include training on institutional protocols and deescalation techniques. Protocols could include different options for responding to inappropriate or prejudiced requests. However, organizational protocols cannot anticipate the nuances of every possible situation, and clinicians should be prepared to approach each situation on a case-by-case basis. Similarly, while deescalation techniques can help prevent a potentially dangerous situation from escalating, they are only useful in scenarios where patients are overtly agitated or aggressive.[66] Opportunities for active learning should also be provided—just as morbidity and mortality conferences allow clinicians to revisit errors without blame or judgment, hospitals can facilitate ad hoc discussions centered around responding to biased patients.[62] These communities can offer healing and serve as safe spaces to discuss an emotionally charged but morally ambiguous topic.[67]

Given trainees' heightened vulnerability, health professions educators should integrate training on patient bias into required curricula. Currently, few health professions schools provide comprehensive education on confronting and managing biased patients, leaving students woefully unprepared to handle discrimination during clinical rotations and training.[68] We recommend that health professions educators include case discussions of biased patients in preclerkship curricula. Faculty members could simulate encounters with biased patients to generate discussion and explore options for responding. For example, the Georgetown University School of Medicine provides short video vignettes to guide medical students in diffusing contentious situations, and the Brigham and Women's Hospital holds a mandatory facilitated workshop to lead newly minted residents through actual scenarios of patient bias.[48,69] These types of exercises can support students in preparing for real-life encounters with biased patients.

Lastly, health professions schools must better sensitize students to issues around culture, cultural differences, and stereotyping.[70] At the Drexel University College of Nursing and Health Professions, faculty discuss power, privilege, and oppression in a leadership course required for all undergraduate health profession students. And at the University of Texas–Pan American nursing department, nursing students spend 2 weeks learning about the impact of culture and stereotypes on nursing care.[71] A better understanding of these topics can help students appreciate what constitutes bias and discrimination and how they manifest at the bedside.

Institutional policies and reporting mechanisms

Health care organizations must develop and enforce clear policies protecting clinicians from patient bias. As stories of discriminatory patients continue to emerge, some institutions have started creating guardrails—such as a decision-guiding algorithm for physicians who experience patient-initiated sexual harassment and abuse at the University of Michigan, and a protocol for transferring the care of prejudiced patients at the Penn State Health Milton S. Hershey Medical Center—but it remains to be seen whether these policies result in true protection for staff.[72–75] We believe that, similar to the Patient's Bill of Rights, which guarantees patients the "right to considerate, respectful care" from all health care professionals, a "Clinician's Bill of Rights" should detail clinicians' right to fair treatment by patients and accompanying persons.[76]

Alongside policies and procedures governing patient bias against clinicians, organizations must implement reporting mechanisms for violations. Reporting mechanisms should be centralized to capture data across an entire organization. An example is the Mayo Clinic, where clinicians who have experienced, witnessed, or are aware of patient bias or misconduct can report incidents to the Integrity and Compliance Office. They are then reviewed and resolved as appropriate.[62] So far, results are promising; in 2018, after a male patient groped a female physician, she immediately reported the incident and the patient was terminated from her practice within 48 hours.[72]

Aggregating data on patient bias can help drive organizational change. By mapping reported incidents, organizations can detect trends and identify departments or groups of clinicians at a higher risk for experiencing patient bias. This type of "hot spotting" analysis can inform revisions to organizational policies and highlight opportunities for providing additional support and education, especially to groups consistently targeted by discriminatory patients.

It is important to acknowledge that fair treatment is a balancing act. There

are situations where the clinician's prejudiced views elicit a patient's "inappropriate" behavior.[77] Achieving patient–clinician relationships free of bias and discrimination requires institutional systems to adjudicate blame between the patient and clinician. A reviewing committee could first speak with both parties individually, engage in a balanced discussion, and then levy appropriate penalties against patients or clinicians at fault. For clinicians, these penalties might include additional training on cultural competency or bias and discrimination in health care. In severe cases, institutions may consider suspending or even terminating a clinician's employment. For patients, penalties might include being transferred to another clinician or clinic. In severe cases, institutions may consider barring the patient from seeking care there.

Legal limitations to addressing patient bias

There are legal restrictions on the extent to which clinicians and institutions can address patient bias. For one, EMTALA prohibits hospitals from denying patient care in an emergency, so it may be necessary to accommodate a patient's reassignment request or ignore discriminatory behavior in an emergent situation.[37] Second, because physicians are not considered employees at many hospitals, they are not protected under Title IX.[63] This can make it challenging to justify physicians' right to a workplace free of discrimination in the legal arena. Lastly, there is always the risk of legal action against clinicians who terminate the patient–clinician relationship. Patient abandonment, defined as the unreasonable discontinuation of treatment without reasonable notice or excuse, and failure to help connect the patient to another provider, can make clinicians vulnerable to a civil lawsuit.[78] It is crucial that clinicians who choose to terminate the patient–clinician relationship only do so after helping the patient secure another qualified provider.

Moving Forward and Conclusions

Culture change is necessary to meaningfully address patient bias against clinicians. Health care organizations must acknowledge and address the prevalence and harm caused by biased patients, rather than continuing to treat discrimination against clinicians as the elephant in the room.[79,80] Furthermore, a culture of nonreporting can undermine efforts to revamp institutional policies and procedures around discriminatory patients. Health care professionals, and particularly trainees, express feeling unsafe or worried about the impacts of reporting on their career prospects.[55,75]

Organizations thus have a responsibility to normalize reporting and support clinicians experiencing discrimination from patients.[76,81,82]

Given the paucity of systematic research on patient bias against clinicians, further investigation is warranted.[6] In particular, research should explore: (1) the causes and impacts of biased patient behavior and (2) interventions to address biased patient behavior. Data from additional studies can motivate sustained organizational change and inform the development of standardized, broadly applicable guidelines for responding to biased patients.

For clinicians, patient bias and discrimination can contribute to emotional exhaustion. Although crucial to high-quality care, the emphasis on patient-centeredness has unintentionally emboldened a "patient's first" approach at the expense of emotional or physical distress to clinicians. We contend that health care organizations must carefully balance their duty to provide high-quality care and tend to the vulnerability of patients, with their responsibility to cultivate a supportive, respectful work environment. Achieving patient–clinician relationships free of bias and discrimination is a complex issue that should be jointly addressed by individual clinicians, health care institutions, and health professions educators. Instead of perpetuating a culture of silence—or worse, denial—we must commit to creating a health care environment where discrimination against both patients and clinicians is unacceptable.

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