

The Dilemma of the Racist Patient

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Abstract

Encounters with racist patients can be distressing, damage the physician-patient relationship, and threaten the collegial environment of the health care setting. Although policies guiding physician interactions may exist, providers may be uncomfortable and left vulnerable in racially charged interactions.

When providers deal with racially intolerant patients, a courteous address of their inappropriate behavior is crucial, after which a dialogue should ensue to identify causes of potentially misplaced anger. Unsuccessful attempts at relationship salvage should be further guided by ethics teams, and in cases of a continued impasse, physicians should absolve themselves of medical duties provided that an appropriate alternative provider is available. Although racism in the health care setting can present a reasonable window to generate productive dialogue to improve race relations, a deeply entrenched and pervasive mindset can be difficult to reverse and should not impede the primary goal of providing timely patient care.

Medicine is not immune from the pervasive grasp of racism. It spills from other dimensions into the realm of healing and poses challenges to those charged with care of the patient. The literature widely documents racist experiences of patients, and differential treatment and health care disparities based on race.^{1,2} As a field, medicine is overshadowed by infamous experiments, such as the Tuskegee and Guatemala experiments, and routine studies that demonstrate poor treatment of minority patients.³⁻⁵ Although much-needed discussion and research is being done on the unfair treatment of patients, little is written about racist patients and their subsequent effect on health care providers and institutions. Such interactions can cause significant distress to providers, damage the therapeutic physician-patient relationship, and threaten the collegial and structural framework of an institution.⁶ The silent acquiescence to patients' racist demands in recent times has become a legal, ethical, and medical dilemma that deserves attention.

No specific example of patient-generated racism is needed

because most minority physicians have experienced an overtly racist interaction with a patient. The true incidence of these interactions is unknown because of underreporting secondary to the tendency of physicians to disregard this behavior in the name of "professionalism," and because reporting of these incidents can sometimes expose how poorly a provider has dealt with the issue and draw admonishment.⁷ In addition to the overt interactions, numerous examples of subtle racism may exist. Manifestations of such subtleties include failure to cooperate with a history and physical examination, use of hostile language, and aggressive body language. *The New York Times* gives the example of an Asian female physician tending to a burly, unreceptive, swastika-tattooed patient.⁸ Such racist interactions are concerning, especially as diversity among newly practicing physicians increases.⁹

Medical Training

In medical school, students are educated to embody compassion and caring. Their care of patients should rise above the fray of poverty, interpersonal conflict, and prejudice.¹⁰ To further this point, medical school curricula have recently introduced standardized patients to teach empathy and simulate difficult encounters in order to help students learn to navigate interactions with aggressive, racist patients. In these scenarios, the patient quickly relinquishes his/her views after an overly understanding student engages the patient in conversation and addresses the source of their angst. Rarely do real-life scenarios play out in such an idealistic manner. The expectation remains, however, that the physician model extreme patience and understanding and honor the patient's autonomy.

The American Medical Association (AMA), a guiding force in medical education, outlines the patient-physician relationship.¹⁰ Such a relationship is a mutually trusting undertaking in which the provider is the patient's advocate and holds the well-being of the patient supreme. The goal is to alleviate suffering, and it should be done without regard to self-interest.¹⁰ The AMA also offers clear instruction to the physician in its code of medical ethics that the physician may not discriminate based on race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination. With regard to the discriminatory practices of patients, the AMA instructs that "patients who use derogatory language or otherwise act in a prejudicial manner toward physicians, other health care professionals, or others

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in the health care setting, seriously undermine the integrity of the patient–physician relationship. Such behavior, if unmodified, may constitute sufficient justification for the physician to arrange for the transfer of care.”¹⁰ The AMA has also recently launched an online ethics journal, *AMA Journal of Ethics*, which explores difficult patient interactions and continues to reiterate the supreme role of the physician. When dealing with patients, the anti-discrimination policy is clearly set forth for physicians.

The Dilemma

Anti-discrimination policies for patients are not as clear. Patients are allowed to pick their own provider, and most institutions allow selection based on gender. Most institutions have no guidelines prohibiting provider-selection based on race, and no published hospital policies explicitly restrict racist demands. Although a culture of respect is encouraged through many hospitals’ published slogans and on websites, at the authors’ institution, no published guidelines exist about the behavior of the patient. When no such policies exist, differential treatment of patients’ racist requests ensues and frustration results. Legally, Title VII of the Civil Rights Act of 1964 bars all employers from discriminating with respect to employment conditions or terms on the basis of race, color, religion, sex, or national origin.¹¹ Honoring a patient’s racist demands that results in discrimination of employees is a violation of that law. Reports of hospitals acceding to racist requests have often resulted in upset staff and lawsuits.^{12–14} Legal language, however, may be foreign in cases of life and death, or scenarios involving significant illness. Physicians in such cases often grant racist requests; for example, a Korean patient underwent life-saving measures only after he was given a non-Japanese provider, and a surgeon granted the wish of a patient’s husband to prohibit African American providers and staff members from entering the operating suite when his wife was undergoing an operation.¹⁵ Some would argue that granting a patient’s bigoted request is akin to institutionalized racism.¹⁶

The doctor–patient relationship is a powerful cornerstone for medicine. Confidence in the physician results in higher satisfaction for both parties and adherence to the treatment regimen on the part of the patient. Prejudiced interactions threaten the therapeutic alliance between patient and provider. Research has investigated how race plays a role in the doctor–patient relationship. When permitted, patients more often pick a provider of their own race.¹⁷ One of 5 African American patients wishes to have an African American provider, and such a desire is often based on a previous negative racist encounter.¹⁸ A patient’s perceptions of discrimination in general correlate with preference for same-race providers, highlighting that a patient’s overall experience with discrimination leads them to prefer a same-race physician. Race-concordant relationships (ie, one in which the provider and patient are of the same race) not only show increased satisfaction, but patients also perceive that their interactions with a racially similar physician are more participatory.^{19–22} In non-English speaking groups, preferences for racially similar physicians are largely based on language similarity, but Latinos feel that

Latino physicians are more empathetic to their complaints.²³ Such views are felt not only by patients, but also by providers. One of 3 physicians feels that patients receiving care from a physician that is of the patient’s own race is superior to that provided by a race-discordant physician.²⁴ Superior outcomes from race-concordant doctor–patient relationships have led some to argue in favor of granting a patient’s wishes for a provider of similar race because doing so can confer additional health benefits.²⁵

Possible Solutions

The solution to such a complex and uncomfortable issue begins with addressing the problem. Patients who make racist remarks and racist demands should be courteously informed that their behavior is inappropriate and hurtful. Failure to voice such a concern results in passive, tacit approval of racist remarks and can be distressing to other patients and staff members in the vicinity.²⁶ It is unfair for a physician, as the leader of the care team, to ignore such behavior because it places staff members, who spend much more time with the patient, in a potentially abusive situation and leaves them feeling helpless.²⁷ Toward this end, appropriate training, beginning in medical school and continuing in residency, in confronting racist patients is needed to ease the too often felt sense of discomfort among providers.^{7,26}

Medical school, although rightly placing patient comfort at the center of dialogue, too often drowns out the personality of the student in the name of professionalism, which becomes a problem as a young physician struggles to reconcile his or her personality with the newly ingrained teaching to remain professional. This internal conflict can lead to frustration. A necessary prerequisite to beginning dialogue is that the physician recognizes his or her own emotional baggage from prior racially charged events and continues to remain professional. Airing the issue can help establish dialogue that can identify underlying causes of the patient’s misplaced anger. An illness and its subsequent hospitalization can make a patient feel vulnerable and helpless, and in those with poor coping mechanisms, misdirection of emotion is not uncommon.

In more difficult scenarios where attempts at dialogue reach an impasse, an ethics team should be consulted. Most institutions have such help available. Their expertise and experience can help in addressing the needs of the patient judiciously. Some institutions have dedicated multidisciplinary teams to help providers deal with dangerous and difficult patients. The implementation of the teams has reduced confrontation and litigation.²⁸ If the impasse remains despite intervention, the physician should step aside after the patient’s care is transitioned to a provider that satisfies the needs of the patient.

In clinically emergent scenarios, ethics consultation or prolonged discussion may not be feasible. In such cases, the patient’s wishes should be honored and attempts should be made to receive permission for life-saving or limb-saving intervention. At large tertiary care centers, the wishes of the patient can be more easily granted than at an outlying facility or rural clinic. If the patient’s wishes cannot be respected in a

life-or-death scenario and the patient continues to refuse care, the principle of patient autonomy dictates that no care can be provided. Much in the same way Jehovah's Witnesses can refuse transfusion of blood products based upon their belief system, any patient can and should be allowed to freely refuse care from a provider.

Racism is a societal disease that is complex and multilayered, and it can be deeply entrenched in the minds of those afflicted and, thus, difficult to eradicate. The manifestations of bigotry in medical settings are only one example of a mindset that likely exists in multiple aspects of life. Hospitals and clinics can become a place to establish dialogue between racially intolerant patients and their providers, but they are not the venue where firmly held racist views can be expected to be wholly reversed. Having the objective to reverse prejudiced beliefs prior to providing care is discordant to the practice of medicine and can harm a patient if an unnecessary delay ensues. Although hospitals should try to avoid offending staff members, there should be an understanding that appropriate and timely patient care is the primary goal in medicine.²⁹ As we move to a more multicultural society, it is the hope of the authors that these already infrequent racist encounters will continue to diminish, and that medical schools and residency programs will train physicians who are highly understanding and culturally competent.

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