# What to do when patient says, “I’d rather have a white doctor.”

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In the current sociopolitical climate, it’s not uncommon for physicians and other health professionals—especially those of color—to be subjected to racist behavior by patients. In the absence of a proactive, principled and coordinated response, the ramifications can be serious and lasting for individuals and toxic to organizational culture. Two social work experts suggest several key actions for leadership to take.

Following are highlights from an article published in the *AMA Journal of Ethics*® (@JournalofEthics) by Ann Marie Garran, PhD, associate professor and director of the Master of Social Work Program at University of Connecticut, Hartford, and Brian M. Rasmussen, PhD, associate professor in the School of Social Work at the University of British Columbia’s Okanagan Campus.

Using a case of an African American resident facing bigotry from her patient and subsequent inaction by her attending physician, the commentary looks at the nature and scope of organizations’ responsibilities to address and prevent expressions of discrimination.

“That racism exists in health care settings should surprise no one—it exists in all domains of contemporary life,” the authors wrote. “What is surprising is just how little racism is formally addressed in medicine.”

They recommend these five responses.

**Don’t pretend the racism doesn’t exist.** How the ethical dilemmas posed by racism are resolved has not been extensively researched. Nevertheless, organizations “must first move beyond the current state of discrimination against clinicians being an ‘open secret,’ and they must acknowledge that reassignment requests motivated by bigotry are problematic and can, in fact, do harm,” the authors wrote.

**Recognize racism’s many manifestations and their effects.** Not all racist expressions are overt, the authors warned. Even microaggressions—slights and other subtle attempts to demean,

marginalize or “otherize”—can cause physicians and other health professionals to feel personally and professionally disrespected.

**Define zero tolerance.** “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. It does mean acknowledging what was said and addressing the racist behavior,” the authors wrote. “What is required is the capacity, skill and willingness to hold these difficult conversations and actually enforce, not just advertise, organizational policies.”

**Encourage white supervisors to step up.** Physicians of color are hesitant to report experiences of racial discrimination to white supervisors, the authors noted. They said this can be attributed to “white fragility,” in which racial stress causes the supervisor to respond defensively, leaving the physician of color feeling she has nowhere to turn. Health care administrators should lean into their roles as leaders to raise awareness of and combat this phenomenon.

**Take it to your leaders.** “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,” the authors wrote. In fact, periodic trainings in cultural competence or diversity will “do little, if anything, to address racism, power and privilege on the interpersonal or institutional levels in the absence of concerted, ongoing organizational commitment.”

The June 2019 issue of the *AMA Journal of Ethics* features numerous perspectives on the ethics of establishing limits to patient preferences. It also gives you an opportunity to earn CME credit.

The AMA Council on Ethical and Judicial Affairs is reviewing existing guidance on disruptive behavior by patients in light of increasing reports of incidents in which patients discriminate against physicians.