REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-19

Subject: Amendment to E-1.2.2, "Disruptive Behavior by Patients"

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Referred to: Reference Committee on Amendments to Constitution and Bylaws

Policy D-65.991, "Discrimination against Physicians by Patients," directs the American Medical Association (AMA) to study "(1) the prevalence, reasons for, and impact of physician, resident/fellow and medical student reassignment based upon patients' requests; (2) hospitals' and other health care systems' policies or procedures for handling patient bias; and (3) the legal, ethical, and practical implications of accommodating or refusing such reassignment requests."

The following analysis by the Council on Ethical and Judicial Affairs (CEJA) examines ethics concerns in this area and offers guidance for physicians when they encounter patients who refuse or demand care based on the physician's perceived personal, rather than professional, characteristics.

REASONS MATTER: DISTINGUISHING PREFERENCE FROM PREJUDICE

It is not known just how often patients discriminate against or sexually harass physicians (and other health care personnel) as data are not systematically collected or publicly reported. However, a growing number of studies and an expanding body of anecdotal reports suggest that such behavior is pervasive in health U.S. care [e.g., 1–7]. In the words of one analyst discrimination by patients is medicine's "open secret" [4].

A survey conducted jointly by Medscape and WebMD in 2017 found that 59% of respondents overall heard an offensive remark from a patient about the physician's personal characteristic, including comments about the physician's weight and political views in addition to comments about age, ethnicity or national origin, gender, race, and sexual orientation [8]. Emergency physicians were significantly more likely to report having experienced bias (83%) than primary care physicians (62%) or specialists (59%). Among respondents, more African American (70%), Asian (69%), and Hispanic (63%) physicians reported hearing biased comments compared to white physicians (55%). The same survey found that male and female physicians experience bias differently, notably in terms of the physician characteristics targeted. For example, female respondents reported experiencing bias more often on the basis of their gender or age than male physicians (41% versus 6% and 36% versus 23%, respectively), while male physicians experienced bias based on their ethnicity or religion somewhat more often than their female colleagues (24% versus 20% and 15% versus 8%, respectively).

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A variety of factors can drive patient behavior that is disrespectful, derogatory, or prejudiced, including mental illness or incapacity or individual life experience, as well as personal beliefs and bias. Different drivers carry different implications for whether, or to what degree, patients can reasonably be held responsible for their problematic behavior. It would not be appropriate to hold patients responsible or blameworthy for statements or actions that are not the product of rational thought in the moment [9]. Thus, physicians' first response to problematic behavior should to explore the reasons underlying the behavior so that they can identify, appreciate, and address potentially treatable conditions. Behavior that outright threatens the safety of health care personnel or other patients calls for prompt action to de-escalate the situation or remove the threat [e.g., 10, 11].

Lingering systemic racism and health disparities in the United States shape the experience of both patients and health care professionals, especially those from nondominant communities [1, 3, 12]. Against this background, patients' reasons for refusing care by a specific physician or requesting a different physician cover a "spectrum of justifiability" [13].

Requests not to be treated by a specific physician may reflect fears or concerns about care that are rooted in systemic discrimination against members of the patient's community or traumatic experiences in a patient's personal history [4, 9, 13]. Requests *for* a physician concordant in ethnicity, religion, or gender may reflect cultural preferences or traditions, for example, a Muslim woman's preference to receive care from a female physician. Such requests may also reflect patients' experience, or reasonable expectation, that they will be better understood by a physician "like them." Evidence suggests that at least for some patients, racial/ethnic or cultural concordance between patient and physician supports more effective communication, enhances satisfaction, and may have clinical benefit [4]. In these situations, it is appropriate to respect patient concerns and preferences, when doing so is clinically feasible.

Requests for an alternative physician based solely on prejudice against personal characteristics of the physician, however, are not justifiable and need not—perhaps should not—be accommodated [4, 9, 13]. Requests based on a physician's (actual or perceived) race/ethnicity, national origin, creed, gender identity, sexual orientation, disability, or other personal characteristic are ethically objectionable.

For physicians and health care institutions faced with patients' strongly held views about who should provide care, then, a central task is distinguishing when a patient's stated preference rests on ethically acceptable reasons and when it reflects unacceptable bias or prejudice. When, that is, will accommodation serve important patient interests and when will it reinforce problematic stereotypes and, in effect if not intent, condone bigotry [2, 9]?

PROTECTING INTERESTS, MINIMIZING HARMS

Patient refusals of care or demands for alternative caregivers challenge physicians, and the institutions in which they work, to protect both the interests of patients and those of physicians. In such situations, physicians' professional obligations to promote patient well-being, respect patients as moral agents and autonomous decision makers, and fulfill the duty to treat without discrimination come into tension in potentially novel ways. Nor do these responsibilities align with physicians' own interests in upholding professional autonomy and themselves being free from discrimination. There are potential harms to both parties whether the physician/institution accommodates bigoted requests and removes the caregiver or requires patient and physician to engage one another in a troubled relationship.

Physicians' fiduciary obligations are fundamental. Physicians are expected to promote patients' interest and well-being without regard to individuals' personal characteristics or behavior, up to and including providing care to individuals whose behavior may be morally repugnant [13, 14]. But whether continuing to provide care or allowing oneself to be withdrawn from a case better fulfills that fiduciary obligation is only intelligible in the individual case. So too are interpretations of how a physician is to respect the autonomy of a patient who asserts moral agency in the form of prejudice, and what the duty to care entails when the recipient behaves in a way that, arguably, is not morally worthy or acceptable. Reaching sound determinations in these matters cannot be done by rote; instead, as one commentator observed, doing so calls for "nuanced ethical judgment" [13].

The American Medical Association *Code of Medical Ethics* enjoins physicians to provide "competent medical care, with compassion and respect for human dignity and rights" [15]. It also acknowledges that, except in emergencies, physicians shall be "free to choose whom to serve" [16].

The Code further delineates the conditions under which a physician may decline to accept a new patient (or provide a specific service to an existing patient [17]. These include when the care requested is outside the physician's competence or scope of practice; when the physician lacks the resources to provide safe, competent, respectful care for the individual; and when meeting this patient's medically needs seriously compromises the physician's ability to provide the care needed by other patients. Importantly, guidance acknowledges that, except in emergencies, a physician may decline to provide care when the patient "is abusive or threatens the physician, staff, or other patients" [17]. At the same time, the *Code* provides that physicians may terminate a relationship with a patient who "uses derogatory language or acts in a prejudicial manner *only if the patient will not modify the behavior*," in which case the physician should arrange to transfer the patient's care [emphasis added] [18].

One approach to determining the ethically appropriate response to prejudiced behavior by patients is to explore the harms—to patients, to physicians and other health care professionals, and to health care institutions and even the wider community—that can result from different possible responses. Who, that is, is harmed by a given response, and in what way?

Thwarting the requests of seemingly bigoted patients for alternative caregivers exposes patients to possible delays in care and poorer health outcomes, should they choose to leave the facility (with or without assistance from the institution). If they do not, or cannot leave, patients are subjected to the experience of receiving medical care from a physician against whom they are biased. Distinguishing between a preference for a different physician and a demand for one is important in thinking about the nature and degree of harm the patient may experience. A preference is "an expression of an inclination that may be gratified or not"; a demand is "more of an ultimatum, in which failure to meet its indicia may be met not only with disappointment but also anger and resentment" [9]. Further, it is important to determine why the patient is making the request/demand, which may have a clinical source, such as delirium, dementia, or psychosis [4, 13], that is outside the patient's control, as opposed to being a stance the patient has voluntarily adopted. And as noted previously, requests/demands may also reflect life experiences that color a patient's response to caregivers for which accommodation may be appropriate.

For physicians and other caregivers, acceding to bigoted demands can send powerful, but unintended and potentially hurtful messages—that minority or female physicians are "not as good" as white male physicians or that patient satisfaction scores are more important to the institution than promoting a safe and ethical working environment [1, 19]. Accommodating bigotry can make institutions complicit in discrimination [19], in the process tacitly condoning or reinforcing an

institutional culture that routinely subjects minority physicians to “barrages of microaggressions and biases” or expects them to serve as “race/ethnicity ambassadors” [1].

Institutions that fail to support staff in the face of prejudice convey that complying with patient demands “is more important than respecting the dignity of both their staff members and the majority of patients, who do not hold such repugnant views (or at least do not openly act on them)” [9]. Institutions, some argue, “have a duty to present a moral face to their community by refusing to honor bigoted or prejudicial requests or demands as a matter of course, up to and including declining to care for such patients (except in emergency situations)” [9, cp. 20].

Regardless of how their institutions respond, for many minority health care professionals, interactions with prejudiced patients are painful and degrading and contributed to moral distress and burnout [4]. *Requiring* physicians to provide care when a patient has openly expressed bias is not ethically tenable. As one physician described his own experience of ultimately declining to work with a particular patient, “After years of feeling that my race was a nonissue, I was subjected to the same kind of hurtful name-calling that I faced in childhood. Even as self-loathing for not having thicker skin began to creep in, I decided that, on this occasion, my feelings would count” [21]. Absent unique situations, institutions should allow physicians to control the decision about whether they will continue to provide care [19]. Some have argued that institutions have a responsibility to monitor such encounters and their effects on an ongoing basis “with the goal of supporting staff and improving the handling of these situations” [4].

Whether patient prejudice against physicians adversely affects quality of care has not been well studied. One experimental study among family practice physicians in the Netherlands concluded that “disruptive behaviours displayed by patients seem to induce doctors to make diagnostic errors” [22]. A companion study attributed this to the fact that the “mental resources” devoted to dealing with patient behavior interfered with “adequate processing of clinical findings” [23]. Evidence does indicate that physician “burnout” can adversely affect patient outcomes [e.g., 24–26]. To the extent that being the target of patient prejudice contributes to the emotional exhaustion, sense of depersonalization, and sense of low personal accomplishment characteristic of burnout, it is reasonable to expect biased behavior to be associated with lower quality of care, particularly if targeted physicians feel they do not have the support of their colleagues or institutions when bias occurs [1, 21, 27, 28].

LAW AND POLICY

Legally, at the federal level how a health care institution responds to prejudiced behavior by patients falls within the scope of the *Emergency Medical Treatment and Active Labor Act* (EMTALA) and by anti-discrimination law in Title VII of the *Civil Rights Act of 1965* (CRA). When patients make requests based on the physician’s race, hospitals are in the position of having to meet EMTALA requirements while respecting physicians’ employment rights [4]. Hospitals can “inform patients of their right to seek care elsewhere and their responsibility to refrain from hateful speech,” but their ability “to remove physicians in response to race-based requests is circumscribed” [4]. Although physicians have not sued under CRA [4], in a case that ultimately settled, an African-American nurse in Michigan sued her employer when she was barred from caring for a white baby at the request of the child’s father, a white supremacist [29].

At present, relatively few institutions have formal policy or procedures for dealing with incidents of patient prejudice, although an increasing number broadly enjoin patients to behave in a respectful manner under policies delineating patient rights and responsibilities and indicate that misconduct will not be tolerated [e.g., 30, 31]. Two notable exceptions are Toronto’s University

Health Network (UHN) and Mayo Clinic, both of which explicitly seek to balance the interests of patients and health care personnel.

UHN's *Caregiver Preference Guidelines* focus on three key questions: whether the preference for an alternative caregiver appears to discriminate against the health care professional on the basis of race, ancestry or other characteristic as provided in the *Ontario Human Rights Code*; whether the request is clinically feasible and/or indicated to a reasonable degree; and whether the caregiver wishes to excuse themselves from caring for the patient [27]. Mayo's recently adopted policy directs staff to step in when they observe behavior that is not in keeping with Mayo Clinic values; address the behavior with the patient, focusing the conversation on Mayo's published values; explain the institution's expectations and set boundaries with the individual; and report the incident to supervisors and document it via a patient misconduct form [27].

RECOMMENDATION

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that Policy D-65.991, "Discrimination against Physicians by Patients," be rescinded; Opinion 1.2.2, "Disruptive Behavior by Patients," be amended by addition and deletion as follows; and the remainder of this report be filed:

> The relationship between patients and physicians is based on trust and should serve to promote patients' well-being while respecting ~~their~~ the dignity and rights of both patients and physicians.
>
> Disrespectful, ~~or~~ derogatory, or prejudiced, language or conduct, or prejudiced requests for accommodation of personal preferences on the part of either physicians or patients can undermine trust and compromise the integrity of the patient-physician relationship. It can make members of targeted groups reluctant to seek or provide care, and create an environment that strains relationships among patients, physicians, and the health care team.
>
> Trust can be established and maintained only when there is mutual respect. Therefore, in their interactions with patients, physicians should:
>
> (a) Recognize that disrespectful, derogatory, or prejudiced language or conduct can cause psychological harm to those ~~they target~~ who are targeted.
>
> (b) Always treat patients with compassion and respect.
>
> (c) Explore the reasons for which a patient behaves in disrespectful, derogatory, or prejudiced ways. Physicians should identify, appreciate, and address potentially treatable clinical conditions or personal experiences that influence patient behavior. Regardless of cause, when a patient's behavior threatens the safety of health care personnel or other patients, steps should be taken to de-escalate or remove the threat.
>
> (d) In general, decline to accommodate patient requests for an alternative physician when the request is solely the product of prejudice against the physician's personal characteristics.
>
> (e) Consider accommodating a patient's request for an alternative physician when the request derives from the patient's adverse personal experience, doing so would promote effective care, and another appropriately qualified physician is available to provide the needed care.

(f) In emergency situations, patients who persist in opposing treatment from the physician assigned may be helped to seek care from other sources. When transfer is not feasible, patients should be informed that care will be provided by appropriately qualified staff independent of the patient's expressed preference.

(~~e~~g)Terminate the patient-physician relationship with a patient ~~who uses derogatory language or acts in a prejudiced manner~~ whose volitional behavior is disrespectful, derogatory, or prejudiced only if the patient will not modify the conduct. In such cases, the physician should arrange to transfer the patient's care when that is feasible.

Physicians, especially those in leadership roles, should encourage the institutions with which they are affiliated to:

(h) Be mindful of the messages the institution conveys within and outside its walls by how it responds to prejudiced behavior by patients.

(i) Promote a safe and respectful working environment and formally set clear expectations for how disrespectful, derogatory, or prejudiced behavior by patients will be managed.

(j) Clearly and openly support physicians, trainees, and facility personnel who experience prejudiced behavior and discrimination by patients.

(k) Collect data regarding incidents of discrimination by patients and their effects on physicians and facility personnel on an ongoing basis and seek to improve how incidents are addressed to better meet the needs of patients, physicians, other facility personnel, and the community.

(Modify HOD/CEJA Policy)

Fiscal Note: Less than $500

REFERENCES

1. Osseo-Asare A, Balasuriya L, Huot SJ, et al. Minority resident physicians' views on the role of race/ethnicity in their training experiences in the workplace. *JAMA Network Open*. 2018;1(5):e182723.
2. Whitgob EE, Blankenburg RL, Bogetz AL. The discriminatory patient and family: strategies to address discrimination towards trainees. *Acad. Med*. 2016;91:S64–S69.
3. Fnais N, Soobiah C, Hong Chen M, et al. Harassment and discrimination in medical training: a systematic review and meta-analysis. *Acad Med*. 2014;89:817–827.
4. Paul-Emile K. Patients Racial Preferences and the Medical Culture of Accommodation. *UCLA Law Rev*. 2012;60:462–504.
5. Reddy S. How doctors deal with racist patients. *The Wall Street Journal*. https://www.wsj.com/articles/how-doctors-deal-with-racist-patients-1516633710. Published January 22, 2018. Accessed July 23, 2019.
6. Novick DR. Racist Patients Often Leave Doctors at a Loss. *Washington Post*. http://wapo.st/2inREoW?tid=ss_mail&utm_term=.778203357cdf. Published October 19, 2017. Accessed July 23, 2019.
7. Haelle T. Physician guidance for dealing with racist patients. *Medscape*. https://www.medscape.org/viewarticle/859354. Published March 17, 2016. Accessed July 23, 2019.
8. Cajigal S, Scudder L. Patient prejudice: when credentials aren't enough. *Medscape*. Published October 18, 2017. Accessed July 23, 2019.
9. Rosoff PM. Discriminatory demands by patients. *Hastings Center Report*. 2018;48(4):7–11.
10. Price O, Baker J. Key components of de-escalation techniques: a thematic synthesis. *Intl J Mental Health Nursing*. 2012;21:310–319.
11. Richmond JS, Berlin JS, Fishkind AB, et al. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup. *West J Emerg Med*. 2012;13(1):17–25.
12. Malat J, Hamilton MA. Preference for same-race health care providers and perception of interpersonal discrimination in health care. *J. Health Social Behavior*. 2006;47(June):173–187.
13. Reynolds KL, Cowden JD, Brosco JP, Lantos JD. When a family requests a white doctor. *Pediatrics*. 2015;136(2):381–386.
14. Lepora C, Danis M, Wertheimer A. No Exceptionalism Needed to Treat Terrorists. *AJOB*. 2009;9(10):53–54.
15. *American Medical Association Code of Medical Ethics*. Principle I. Available at. https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics. Published 2017. Accessed July 23, 2019.
16. *American Medical Association Code of Medical Ethics*. Principle VI. Available at. https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics. Published 2017. Accessed July 23, 2019.
17. *American Medical Association Code of Medical Ethics*. Opinion 1.1.2 Prospective patients. Available at https://policysearch.ama-assn.org/policyfinder/detail/1.1.2?uri=%2FAMADoc%2FEthics.xml-E-1.1.2.xml. Published 2017. Accessed July 23, 2019.
18. *American Medical Association Code of Medical Ethics*. Opinion 1.2.2. Disruptive behavior by patients. Available at https://policysearch.ama-assn.org/policyfinder/detail/transfer%20patient?uri=%2FAMADoc%2FEthics.xml-E-1.2.2.xml. Published 2017. Accessed July 23, 2019.
19. Anstey K, Wright L. Responding to discriminatory requests for a different healthcare provider. *Nursing Ethics*. 2013;1–11.

20. McCruden P. Dealing with racist patient requests: law, rights, and Catholic identity. *Health Care Ethics USA*. 2017;Summer:21–29.
21. Jain SH. The racist patient. Ann. Intern Med. 2013;158:632.
22. Schmidt HG, van Gog T, CE Schuit S, et al. Do patients' disruptive behaviours influence the accuracy of a doctor's diagnosis? a randomised experiment. *BMJ Quality & Safety*. 2017;26:19–23.
23. Mamede S, Van Gog T, Schuit SCE, et al. Why patients' disruptive behaviours impair diagnostic reasoning: a randomised experiment. *BMJ Quality & Safety*. 2017;26:13–18.
24. Lu DW, Dresden S, McCloskey C, Branzetti J, Gisondi MA. Impact of burnout on self-reported patient care among emergency physicians. *West J Emerg Med*. 2015;16(7):996–1001.
25. Dewa CS, Loong D, Bonato S, Trojanowski L. The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review. *BMJ Open*. 2017;7:e01514.
26. Halbesleben JRB, Rathert, C. Lining physician burnout and patient outcomes: exploring the dyadic relationship between physicians and patients. *Health Care Management Review*. 2008;33(1):29–39.
27. Warsame RM, Hayes SN. Mayo Clinic's 5-step policy for responding to bias incidents. *AMA Journal of Ethics*. 2019;21(6):E521–529.
28. Okwerekwu JA. The patient called me 'colored girl'. the senior doctor training me said nothing. *Stat*. https://www.statnews.com/2016/04/11/racism-medical-education/. Published April 11, 2016. Accessed July 23, 2019.
29. Castillo M. Detroit nurse claims hospital barred African American staff from caring for white child. *CBS News*. https://www.cbsnews.com/news/detroit-nurse-claims-hospital-barred-african-american-staff-from-caring-for-white-child/. Published February 19, 2013.
30. Penn State Health. Patient Rights Policy. *Penn State Health*. https://hmc.pennstatehealth.org/documents/11396232/11459793/Patient+Rights+Policy+PC-33-HAM/b4f54eb1-7183-43cb-a606-640be66a84c8. Published May 2018. Accessed July 23, 2019.
31. Massachusetts General Hospital. Patient Rights and Responsibilities. *Massachusetts General Hospital*. https://www.massgeneral.org/advocacy/rights/default.aspx. Published 2019. Accessed July 23, 2019.