

REPORTS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

The following reports were presented by Kathryn L. Moseley, MD, Chair:

1. COMPETENCE, SELF-ASSESSMENT AND SELF-AWARENESS

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws

HOUSE ACTION: RECOMMENDATIONS ADOPTED

REMAINDER OF REPORT FILED

See Policy H-140.829

The expectation that physicians will provide competent care is central to medicine. This expectation shaped the founding mission of the American Medical Association (AMA) and runs throughout the *AMA Code of Medical Ethics* [1-4]. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society [5]. The profession promises that practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses [6-9].

Yet despite the centrality of competence to professionalism, the *Code* has not hitherto examined what the commitment to competence means as an ethical responsibility for individual physicians in day-to-day practice. This report by the Council on Ethical and Judicial Affairs (CEJA) explores this topic to develop ethics guidance for physicians.

DEFINING COMPETENCE

A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional assessments of physicians' technical knowledge and skills. However, this report is not concerned with matters of technical proficiency assessed by medical schools and residency programs, specialty boards (for purposes of certification), or hospital and other health care organizations (e.g., for privileging and credentialing). Such matters lie outside the Council's purview.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. For purposes of this analysis, competence is understood as "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served" and as "developmental, impermanent, and context dependent" [10].

Moreover, the Council is keenly aware that technical proficiency evolves over time—what is expected of physicians just entering practice is not exactly the same as what is expected of mid-career physicians or physicians who are changing or re-entering practice or transitioning out of active practice to other roles. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues.

The concept that informs this report differs as well from the narrower definition of competence as the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion of competence that encompasses deeper aspects of wisdom, judgment and practice that enable physicians to assure patients, the public, and the profession that they provide safe, high quality care moment to moment over the course of a professional lifetime.

FROM SELF-ASSESSMENT TO "INFORMED" SELF-ASSESSMENT

Health care institutions and the medical profession as a whole take responsibility to regulate physicians through credentialing and privileging, routinely testing knowledge (maintenance of certification, requirements for continuing education, etc.) and, when needed, taking disciplinary action against physicians who fail to meet expectations for competent, professional practice. However, the better part of the responsibility to maintain competence rests with

physicians’ “individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs to maintain a level of competence commensurate with [their] clinical roles” [11].

Self-assessment has thus become integral to many appraisal systems [5, 10, 12-16]. Yet clinicians and trainees tend to assess their peers’ performance more accurately than they do their own—for example, those who perform in the bottom quartile tend to over-estimate their abilities, while those in the top quartile tend to under-estimate themselves [5,12,13,17].

Self-assessment involves an interplay of factors that can be complicated by personal characteristics (e.g., gender, ethnicity, or cultural background); by lack of insight or ability to be self-observant in the moment; and by external factors, such as the purpose of self-assessment [12,18]. The published literature also indicates that interventions intended to enhance self-assessment may seek different goals—improving the accuracy of self-assessors’ perceptions of their learning needs, promoting appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

Thus self-assessment tools alone are not sufficient measures of physicians’ ability to provide safe, high quality care. Feedback from third parties is essential [19]. However, physicians can be hesitant to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of concern that soliciting feedback could adversely affect their relationships with those whom they approach [20]. They may also question the accuracy and credibility of the assessment process and the data it generates [21]. And they are not sure how to use information that is not congruent with their self-appraisals [20].

To be effective, feedback must be valued by those being assessed as well as by those offering assessment [14]. When there is tension between the stated goals of assessment and the implicit culture of the health care organization or institution, assessment programs can too readily devolve into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20]. Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews (“360° reviews”), for example, are generally better suited to providing feedback on communication and interpersonal skills than on technical knowledge or skills—and easy for evaluators to understand and use [14]. High quality feedback will come from multiple sources; be specific and focus on key elements of the ability being assessed; address behaviors rather than personality or personal characteristics; and “provide both positive comments to reinforce good behavior and constructive comments with action items to address deficiencies” [22]. Beyond such formal mechanisms, physicians should welcome and seek out informal input from colleagues. They should be willing to offer timely comments to colleagues as well.

One study among physicians and trainees found that participants interpreted and responded to multiple types of information, such as cognitive and affective data, from both formal and informal sources [23]. Participants described “critically reflecting ‘in action,’ that is, during an activity or throughout the day”:

I think we do a lot of it without thinking of it as reflection. We do it every day when we look at a patient’s chart. You look back and see the last visit, “What did I do, or should I have done something different?” I mean that’s reflection, but yet I wouldn’t have thought of that as self-assessment or self-reflection, but we do it dozens of times a day [23].

EXPERTISE & EXPERT JUDGMENT

On this broad understanding of competence, physicians’ thought processes are as important as their knowledge base or technical skills. Thus, understanding competence requires understanding something of the nature of expertise and processes of expert reasoning, themselves topics of ongoing exploration [24,25,26,27].

Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s] automatic resources and to transition appropriately to a greater reliance on effortful processes when needed” [24], a practice described as “slowing down.” Knowing when to slow down and be reflective has been demonstrated to improve diagnostic accuracy and other outcomes [26]. To respond to the unexpected events that often arise in a clinical situation, the physician must “vigilantly monitor relevant environmental cues” and use these as signals to slow down, to transition into a more effortful state [25]. This can happen, for example, when a surgeon confronts an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should” serves as a critical marker for intraoperative surgical judgment [24].

Influences on Clinical Reasoning

Physicians' skills of clinical reasoning develop through education, training, and experiences. Every physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or differ from the analytical and investigative processes of their colleagues in innumerable ways. Nonetheless, all physicians are susceptible to certain common pitfalls in reasoning, notably relying unduly on heuristics and habits of perception, and succumbing to overconfidence.

Physicians use time-saving cognitive short cuts (heuristics) to help identify and categorize relevant information. But such short cuts can also mislead physicians to miscategorize information based on seeming similarity or to place too much weight "on examples of things that come to mind easily [28]. Other common cognitive missteps can derail clinical reasoning as well, including misperceiving a coincidental relationship as a causal one, or the tendency to remember information transferred at the beginning or end of an exchange but not information transferred in the middle [28,29,30].

Like every other person, physicians can also find themselves prone to conscious or unconscious habits of perception or biases. They may allow unquestioned assumptions based on a patient's race or ethnicity, gender, socioeconomic status, or health behavior, for example, to shape how they perceive the patient and how they engage with, evaluate, and treat the individual [31]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or dismiss contradicting information that does not fit into predetermined beliefs [28]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.

So too, despite their extensive training, physicians, like all people, are often poor at identifying the gaps in their knowledge [28,30]. They may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement [30]. Overconfidence in one's abilities can lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of others, or not acknowledging one's limits [28,30].

Physicians should be aware of the information they do and do not have and they acknowledge that many factors can and will influence their judgment. They should keep in mind the likelihood of diseases and conditions and take the time to distinguish information that is truly essential to sound clinical judgment from the wealth of possibly relevant information available about a patient. They should consider reasons their decisions may be wrong and seek alternatives, as well as seek to disprove rather than confirm their hypotheses [28]. And they should be sensitive to the ways in which assumptions may color their reasoning and not allow expectations to govern their interactions with patients.

Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming aware of areas in which their skills are not at their strongest and seeking additional education or consulting with colleagues, physicians can enhance their practice and best serve their patients.

FROM INFORMED SELF-ASSESSMENT TO SELF-AWARENESS

Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally conceived has significant shortcomings, several scholars have argued that a different understanding of self-assessment is needed, along with a different conceptualization of its role in a self-regulating profession [32]. Self-assessment, it is suggested, is a mechanism for identifying both one's weaknesses and one's strengths. One should be aware of one's weaknesses in order to self-limit practice in areas in which one has limited competence, to help set appropriate learning goals, and to identify areas that "should be accepted as forever outside one's scope of competent practice" [32]. Knowing one's strengths, meanwhile, allows a physician both to "act with appropriate confidence" and to "set appropriately challenging learning goals" that push the boundaries of the physician's knowledge [32].

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [3]. The ability to monitor oneself in the moment is critical to physicians' ethical responsibility to practice safely, at the top of their expertise but not beyond it.

Self-awareness, in the form of attentive self-observation, alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to “slow down” during a procedure is critical to competent professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [25].

Physicians should also be sensitive to the ways that interruptions and distractions, which are common in health care settings, can affect competence in the moment [34,35], by disrupting memory processes, particularly the “prospective memory”—i.e., “a memory performance in which a person must recall an intention or plan in the future without an agent telling them to do so”—important for resuming interrupted tasks [35,36]. Systems-level interventions have been shown to help reduce the number or type of interruptions and distractions and mitigate their impact on medical errors [37].

A key aspect of competence is demonstrating situation-specific awareness in the moment of being at the boundaries of one’s knowledge and responding accordingly [33]. Slowing down, looking things up, consulting a colleague, or deferring from taking on a case can all be appropriate responses when physicians’ self-awareness tells them they are at the limits of their abilities. The capacity for ongoing, attentive self-observation, for “mindful” practice, is an essential marker of competence broadly understood:

Safe practice in a health professional’s day-to-day performance requires an awareness of when one lacks the specific knowledge or skill to make a good decision regarding a particular patient This decision making in context is importantly different from being able to accurately rate one’s own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of self-efficacy and ongoing ‘reflection-in-practice,’ addressing emergent problems and continuously monitoring one’s ability to effectively solve the current problem [32].

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills [32]. Self-aware physicians are also alert to how external stressors—the death of a loved one or other family crisis, or the reorganization of their practice, for example—may be affecting their ability to provide care appropriately at a given time. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

Physicians’ ability to be sufficiently self-aware to practice safely can be compromised by illness, of course. In some circumstances, self-awareness may be impaired to the point that individuals are not aware of, or deny, their own health status and the adverse effects it can or is having on their practice. In such circumstances, individuals must rely on others—their personal physician, colleagues, family, social acquaintances, or even patients—to help them recognize and address the situation. Physicians have a responsibility to one another and to patients to promote health within the physician community, a responsibility that extends to intervening when a colleague’s ability to practice safely is compromised [E-9.3.2]. Physicians who are unable to recognize that they are impaired due to cognitive disability or other illness are not necessarily blameworthy or unethical, unless they decline to address their condition and modify their practice once others have drawn attention to their inability to continue practicing medicine safely.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

For physicians, the ideal is not simply to be “good” practitioners, but to excel throughout their professional careers. This ideal holds not just over the course of a sustained clinical practice, but equally when physicians re-enter practice after a hiatus, transition from active patient care to roles as educators or administrators, or take on other functions in health care. Self-assessment and self-awareness are central to achieving that goal.

A variety of strategies is available to physicians to support effective self-assessment and help them cultivate the kind of self-awareness that enables them to “know when to slow down” in day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in the form of written descriptions, audio or video recording, or photos of encounters with patients that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to improve practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike standardized examinations, they are drawn from one’s actual work and require self-reflection [15].

As noted above, to be effective, self-assessment must be joined with input from others. Well-designed multi-source feedback can be useful in this regard, particularly for providing information about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple response that elicits feedback about how well one maintains trust and professional relationships with patients, one's communication and teamwork skills, and accessibility offers a valid, reliable tool that can have practical value in helping to correct poor behavior and, just as important, consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful feedback will not have the rigor of a validated tool but can accomplish similar ends.

Reflective practice, that is, the habit of using critical reflection to learn from experience, is essential to developing and maintaining competence across a physician's practice lifetime [38]. It enables physicians to "integrate personal beliefs, attitudes, and values in the context of professional culture," and to bridge new and existing knowledge. Studies suggest that reflective thinking can be assessed, and that it can be developed, but also that the habit can be lost over time with increasing years in practice [38].

"Mindful practice"—being fully present in everyday experience and aware of one's own mental processes (including those that cloud decision making) [39]—sustains the attitudes and skills that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on behavior over consciousness, erects barriers to mindful practice, while an individual's unexamined negative emotions, failure of imagination, and literal-mindedness can do likewise. Physicians can cultivate mindfulness in myriad ways; e.g., through meditation, keeping a journal, reviewing videos of encounters with patients, or seeking insight from critical incident reports [39].

"Exemplary physicians," one scholar notes, "seem to have a capacity for self-critical reflection that pervades all aspects of practice, including being present with the patient, solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining their own values" [39].

RECOMMENDATION

Based on the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians' technical knowledge and skills.

However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should strive to:

- (a) Cultivate continuous self-awareness and self-observation.
- (b) Recognize that different points of transition in professional life can make different demands on competence.
- (c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations.
- (d) Seek feedback from peers and others.
- (e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient's best interest.

- (f) Maintain their own health, in collaboration with a personal physician, in keeping with ethics guidance on physician health and wellness.
- (g) Intervene in a timely, appropriate, and compassionate manner when a colleague's ability to practice safely is compromised by impairment, in keeping with ethics guidance on physician responsibilities to impaired colleagues.

Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

REFERENCES

1. *American Medical Association Code of Medical Ethics*. Principle I. Available at <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>. Accessed August 20, 2016.
2. *American Medical Association Code of Medical Ethics*. Opinion 11.2.1, Professionalism in health care systems. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
3. *American Medical Association Code of Medical Ethics*. Opinion 1.2.3, Consultation, referral and second opinions. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
4. *American Medical Association Code of Medical Ethics*. Opinion 1.1.6, *Quality*. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
5. Gordon MJ. A review of the validity and accuracy of self-assessments in health professions training. *Acad Med*. 1991;66:762–769.
6. *American Medical Association Code of Medical Ethics*. Principle II. Available at <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics>. Accessed August 20, 2016.
7. *American Medical Association Code of Medical Ethics*. Opinion 9.4.2, Reporting incompetent or unethical behavior by colleagues. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
8. *American Medical Association Code of Medical Ethics*. Opinion 9.4.3, Discipline and medicine. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
9. *American Medical Association Code of Medical Ethics*. Opinion 8.6, Promoting patient safety. Available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed August 20, 2016.
10. Epstein RM, Hundert EM. Defining and assessing professional competence. *JAMA*. 2002;287(2):226–235.
11. Epstein RM, Siegel DJ, Silberman J. Self-monitoring in clinical practice: a challenge for medical educators. *J Contin Educ Health Professions*. 2008;28(1):5–13.
12. Colthart I, Bagnall G, Evans A, et al. The effectiveness of self-assessment on the identification of learner needs, learner activity, and impact on clinical practice: BEME Guide no. 10. *Medical Teacher*. 2008;30:124–145.
13. DA, Mazmanian PE, Fordis M, et al. Accuracy of physician self-assessment compared with observed measures of competence: a systematic review. *JAMA*. 2006;296:1094–1102.
14. Whitehouse A, Hassell A, Bullock A, et al. 360 degree assessment (multisource feedback) of UK trainee doctors: filed testing of team assessment behaviors (TAB). *Medical Teacher*. 2007;29:171–178.
15. O'Sullivan P, Greene C. Portfolios: possibilities for addressing emergency medicine resident competencies. *Acad Emerg Med*. 2002;9(11):1305–1309.
16. Leigh IW, Smith IL, Bebeau M, et al. Competency assessment models. *Professional Psychology: Research and Practice*. 2007;38(5):463–473.
17. Lipsett PA, Harris I, Downing S. Resident self-other assessor agreement: influence of assessor, competency, and performance level. *Arch Surg*. 2011;146(8):901–906.
18. Svirko E, Lambert T, Goldacre MJ. Gender, ethnicity and graduate status, and junior doctors' self-reported preparedness for clinical practice: national questionnaire surveys. *J Royal Society Med*. 2014;107(2):66–74.
19. Dunning D. Strangers to ourselves? *The Psychologist*. 2006;19(10):600–603.
20. Mann K, van der Vleuten C, Eva K, et al. Tensions in informed self-assessment: how the desire for feedback and reticence to collect and use it can conflict. *Acad Med*. 2011;86(9):1120–1127.
21. Sargeant J, Mann K, Ferrier S. Exploring family physicians' reactions to multisource feedback: perceptions of credibility and usefulness. *Medical Education*. 2005;39:497–504.
22. Jackson JL, Kay C, Jackson WC, Frank M. The quality of written feedback by attendings of internal medicine residents. *J Gen Intern Med*. 2015;30(7):973–978.
23. Sargeant J, Amson H, Chesluk B, et al. The processes and dimensions of informed self-assessment: a conceptual model. *Acad Med*. 2010;85:1212–1220.

24. Moulton CE, Regehr G, Mylopoulos M, MacRae HM. Slowing down when you should: a new model of expert judgment. *Acad Med.* 2007;82(10 Suppl):S109–S116.
25. Moulton C, Regehr G, Lingard L, et al. Slowing down to stay out of trouble in the operating room: remaining attentive in automaticity. *Acad Med.* 2010;85(10):1571–1577.
26. Croskerry P. Achieving quality in clinical decision making: cognitive strategies and detection of bias. *Acad Emerg Med.* 2002;9(11):1184–1204.
27. Sklar DP. How do we think? can we learn to think? *Acad Med.* 2014;89:191–193.
28. Klein JG. Five pitfalls in decisions about diagnosis and prescribing. *BMJ.* 2005;330:781–784.
29. Croskerry P, Petrie DA, Reilly B, Tait G. Deciding about fast and slow decisions. *Acad Med.* 2014;89:197–200.
30. Kadar N. Peer review of medical practices: missed opportunities to learn. *AJOG.* 2014; Dec:596–601.
31. Cooper LA, Roter DL, Carson KA, et al. The association of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *Am J Public Health.* 2012;102:979–987.
32. Eva KW, Regehr G. Self-assessment in the health professions: a reformulation and research agenda. *Acad Med.* 2005;80(10 Suppl):S46–S54.
33. Eva KW, Regehr G. Knowing when to look it up: a new conception of self-assessment ability. *Acad Med.* 2007;82(10 Suppl): 581–584.
34. Rivera AJ, Karsh B-T. Interruptions and distractions in healthcare: review and reappraisal. *Qual Saf Health Care.* 2010;19(4):304–312.
35. Grundgeiger T, Sanderson P. Interruptions in health care: theoretical views. *Intl J Med Informatics.* 2009;78:293–307.
36. Monsell S. Task switching. *TRENDS in Cog Sciences.* 2003;7(3).
37. Relihan E, O'Brien V, O'Hara S, et al. The impact of a set of interventions to reduce interruptions and distractions to nurses during medication administration. *Qual Saf Health Care.* 2010; May 28.
38. Mann K, Gordon J, MacLeod A. Reflection and reflective practice in health professions education: a systematic review. *Adv in Health Sci Educ.* 2009;14:595–621.
39. Epstein RM. Mindful practice. *JAMA.* 1999;282(9):833–839.

2. AMENDMENT TO E-1.2.2, “DISRUPTIVE BEHAVIOR BY PATIENTS”

Reference committee hearing: see report of Reference Committee on Amendments to Constitution and Bylaws.

HOUSE ACTION: REFERRED

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).

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 be 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.
- (eg) 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.

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. Haele 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.