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Discrimination and Patient-Centered Care

Organizational best-practice guidelines can provide ethical and legal guidance.

Today's healthcare organizations have embraced the concept of patient-centered care, ensuring that clinical care is respectful and responsive to individual patient preferences, needs and values. Patient-centered care is epitomized by shared decision making between patients and clinical care teams. Adding further weight to the patient-centered care aim is its linkage to a basic ethical concept underpinning the delivery of healthcare: respect for patients' autonomy. Achieving patient-centered care and adhering to the principle of autonomy are foundational to the success of any clinician-patient encounter.

With the emphasis on patient-centered care has come related ethical concerns that ask the question,

are there limits to a patient's autonomy? Many of those concerns have focused on problems related to end-of-life decision making, such as medical futility, when patients or family members demand interventions that are contrary to the standard of care or to the patient's advance directive. However, other situations center on whether limiting patient autonomy is justifiable.

The same basic dilemma regarding the scope of patient autonomy relates to patients who demand that their healthcare provider be of a certain race or ethnic group. The issue can manifest itself in a variety of clinical scenarios, ranging from requests that seem quite reasonable to those that are questionable or flagrantly racist. The American College of Physicians'

Ethics Manual affirms that "a patient is free to change physicians at any time." The American Medical Association's *Code of Medical Ethics* similarly affirms a patient's right "to a second opinion" and "reasonable assistance in making alternative arrangements for care," if changing care. It is understandable, for example, for a woman to request a female gynecologist or a male to request a male physician for his colonoscopy. To the extent possible, hospitals should try to accommodate such reasonable requests, whether they are based on religious beliefs, cultural norms or personal values.

Discrimination's Effect on Staff

However, other types of patient requests or demands regarding their choice of caregiver seem less ethically clear. One example is when a patient demands that his or her caregiver be of a specific race due to racist beliefs. Consider a white male patient who demands that his ED physician not be African-American or a Christian female who requests that no caregivers of Muslim faith be involved in her care while in the hospital. Once, in a rural outpatient clinic, a white, bipolar patient dismissed Andrew Huang and, in her growing impatience and anxiety, yelled "I don't want to see some stupid Chinese

ACHE's Code of Ethics

The ACHE *Code of Ethics* is clear in its expectations for healthcare executives in terms of discrimination. In relationship to the executives' responsibility to employees, "There is zero tolerance for bigotry." Healthcare leaders are called to promote "a culture of inclusivity that seeks to prevent discrimination on the basis of race, ethnicity, religion, gender, sexual orientation, age or disability." In relationship to executives' responsibilities to the clinical setting, they are to "avoid practicing or facilitating discrimination and institute safeguards to prevent discriminatory organizational practices."

student!” She then demanded to be seen by a specific doctor.

Discrimination in healthcare is an unpleasant topic. Yet, like other disturbing issues that resonate in our society, we need to address discrimination’s impact on clinical care and the delivery of healthcare. When a patient requests a different provider out of bigotry, how far must clinicians and healthcare organizations go to fulfill that request?

A 2014 *JAMA* article by Meghan Lane-Fall, MD, a female African-American critical care doctor, poignantly describes a physician’s experience with a bigoted patient’s demands, as well as the “befuddled” looks from her patients that she was a physician. However, as Lane-Fall notes, “my discomfort with the patient’s beliefs does not trump their right to specify the conditions of their care.”

Such situations raise challenging ethical and legal issues and affect the caregiver-patient relationship. Hospitals that stipulate policy that requires clinicians to fulfill such patient requests pose a dilemma, as a hospital leader would neither want to condone discrimination nor allow doctors to fail to provide appropriate care.

In addition, hospital caregivers may experience moral distress when a patient expresses preferences based on discriminatory thinking. The presence of moral distress can have a major impact on morale and staff burnout. For example, how do hospitals support a gay nurse who is facing burnout as a result of continued moral distress over

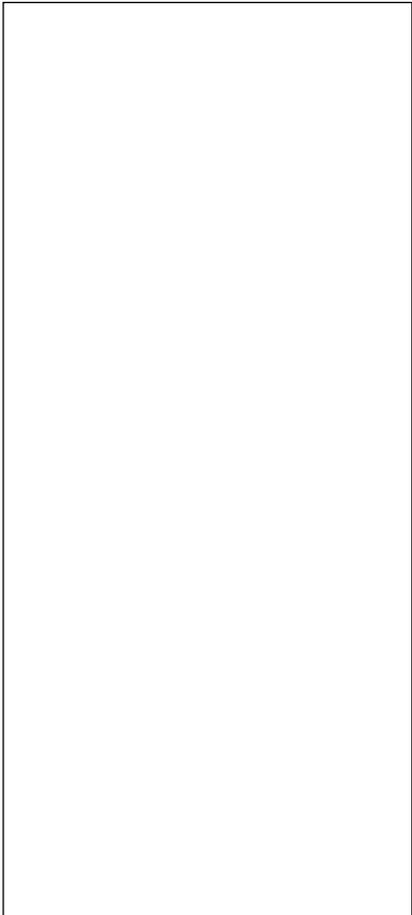
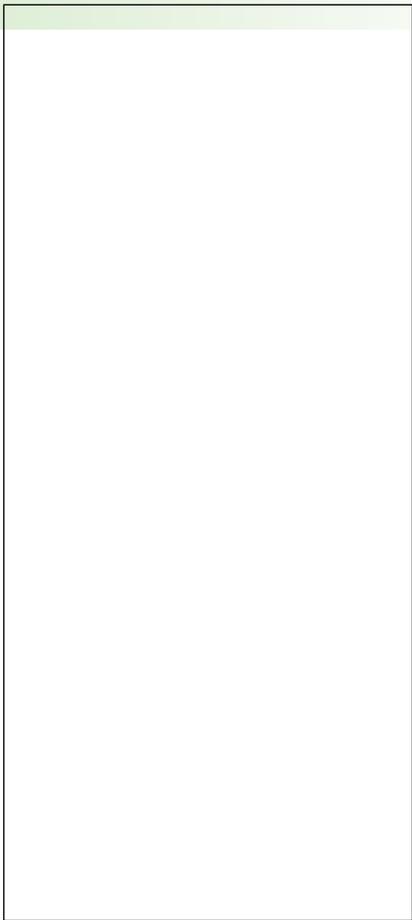
repetitive verbal abuse received from homophobic patients?

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Organizational Response to Discrimination

Because these sorts of encounters occur in the context of a healthcare organization, administrative and clinical leaders have an important role to play in addressing this concern. Specifically, organizational leaders need to learn and recognize the many ethical and legal issues surrounding race-based patient demands, develop thoughtful practice guidelines for responding to such requests and assess the impact of those guidelines. The creation of guidelines should take place within a thoughtful process involving many professionals from a variety of disciplines. Practice guidelines can unify responses in patient-care decisions and contribute to staff morale by offering a comprehensive approach for responding to these situations.

Kiimani Paul-Emile, JD, PhD, and colleagues, in a Feb. 25, 2016, article in the *New England Journal of Medicine*, describe a useful starting framework for developing organizational practice guidelines regarding the management of a situation involving a racist patient. They focus on five elements to help direct whether to accommodate a bigoted request: the patient’s medical



stability, decision-making capacity and reasons for the request; the organization's ability to accommodate; and the impact of the request on the medical team.

Their guidelines describe clear cases involving either patients who are medically stable or those who lack decision-making capacity. For example, if a bigoted patient with decision-making capacity is medically unstable and in need of immediate care, timely treatment takes priority. However, Paul-Emile and colleagues note, if a stable but racist patient lacks decision-making capacity, clinicians should attempt to persuade and negotiate care approaches to treat the patient.

A medically stable patient with decision-making capacity who makes a racist request presents a more difficult set of concerns. A key factor in determining whether to accommodate is the availability of resources. Some healthcare settings, such as small, rural or critical access hospitals, have limited medical personnel and resources to meet this demand. A medically stable patient can accept the available resources or agree to be transferred to another facility that can accommodate the demand.

Another potential disqualifier for accommodation is when a stable patient absolutely refuses to negotiate or compromise his or her discriminatory

position and is verbally abusive in the exchange. If all staff approaches for accommodation have been exhausted, the patient has been warned not to abuse staff and he or she continues to be uncooperative, then the patient may be deemed as undeserving of a replacement caregiver.

Despite the useful strategy expressed by Paul-Emile and colleagues, they indicate, "No ethical duty is absolute, and reasonable limits may be placed on unacceptable patient conduct." Unfortunately, no algorithm can provide easy answers to these complex clinician scenarios.

The concept of patient-centered healthcare is challenged by discriminatory patient demands. Healthcare professionals have an ethical responsibility to ensure that patients receive needed care. As frustrating as it may be for clinical staff, meeting the patient's healthcare need may include attempting to accommodate the patient's discriminatory demand by transferring the patient to another provider. Organizational practice guidelines can provide ethical and legal guidance to caregivers for identifying and resolving those rare situations in which refusing discriminatory requests is justified. ▲

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Guidelines for Addressing Discrimination Among Patients

- Recognize that discrimination exists in the delivery of healthcare and that it creates moral stress and uncertainty for staff.
- Develop practice guidelines to assist clinicians. The guidelines should be carefully written based on the thoughtful advice of legal counsel, an ethics committee, human resources, administration and clinician services representatives. Practice guidelines can promote a consistent response to discriminatory demands.
- Develop an education program to familiarize staff with the ethical and legal underpinning of the practice guidelines. Training should cover how to effectively communicate and negotiate with patients who express discriminatory demands.
- Ensure that helpful resources, such as an ethics committee or risk-management staff, are readily available when clinicians face challenging situations.
- Assess the practice guidelines and any related programs to determine if they foster a consistent ethically and legally grounded approach to patient-centered care and address staff's uncertainty and stress. Whenever such a patient encounter occurs, a retrospective review should be undertaken to evaluate what was done well and what could have been better. This evaluation process can improve future patient-staff encounters when the issue recurs. It also benefits the involved parties and creates a culture of open reflection.