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Discrimination in the Medical Profession—Unfortunately, It's a Two-Way Street

By Linda Hay and Matt Brandabur

Many practitioners are familiar with office protocol for issues of workplace discrimination. It is all too common, however, for practitioners to experience discrimination from a different source—patients. A recent survey, *Patient Prejudice: When Credentials Aren't Enough* found:

- 59 percent of doctors had a patient make an offensive remark regarding their ethnicity, race, age, gender, accent, religion, weight, sexual orientation or political views.[1]
- 11 percent of patients surveyed heard a healthcare professional make an offensive remark about them in the last five years.[2]
- 83 percent of emergency medicine physicians say they have heard offensive remarks from patients.[3]

To successfully address discrimination in medicine, practitioners must understand, manage and educate themselves. Employers—including institutions, hospitals, medical facilities, clinics and doctors' offices—should develop policies and procedures to create a safe, nondiscriminatory environment.

The *Patient Prejudice* study found some startling results, including that "[i]n the past five years, almost one-half of physicians say they've had a patient request a different clinician on the basis of their personal characteristics or background or the characteristics or background of a clinician to whom they were referred. About one-quarter of physicians told [the study] that in that same period, a patient has written a complaint about them because of their personal characteristics or background."[4]

The American Medical Association's Ethical Rules state physicians, "cannot refuse to care for patients based on race, gender, sexual orientation, gender identity or any other criteria that would constitute invidious discrimination." Discrimination in the workplace, arising from dealings with coworkers or patients may be actionable.

Race/National Origin

Racial bias, explicit or implicit, can have an immense negative effect on practitioners and patients. *American Nurse Today* discussed an event that triggered a lawsuit: A neonatal ICU registered nurse sued a Michigan hospital for discrimination when it honored a request from a white father to bar African-American nurses from caring for his baby.

The hospital honored the request for some time before correcting the discriminatory action. The nurse settled the case with payment for emotional stress and harm to her reputation.[5]

Age

"By 2030, one in five Americans will be age 65 or older. There will be 61 million "young-old" (ages 65 to 84) and nine million "old-old" (ages 85 and older)."[6] This study raised many issues practitioners face from an aging demographic.

Indeed, in the *Patient Prejudice* study, offensive remarks regarding age was the most common bias practitioners heard from patients.

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"Whether provider ageism is explicit or implicit, it puts older patients at risk for under-treatment and over-treatment. Healthcare providers must also be attentive to unique features of medical encounters with older patients."[7]

Studies suggest that patient bias is indiscriminate in that comments can be derogatory to both older practitioners who are viewed as being too old to be competent and to younger practitioners who are perceived as inexperienced or incompetent. For example, some patients will comment on the age of physicians who appear young with, "You don't look old enough to be a physician" or "Hi, Doogie."

Gender

Gender discrimination presents numerous problems for the healthcare community from patient preference of physician, to wage equality, to representation in the workforce.[8] Studies have shown women are treated differently in clinical situations.[9] For example, a female physician who doesn't wear a white coat is often assumed to be a nurse.

Religion

Religious discrimination similarly presents a multitude of issues for institutions, practitioners and patients. Most recently, it has been at the forefront of various legal and political issues. While existing federal and state laws protect healthcare workers who express religious objections to certain procedures, it has often been an unsettled area.

In January 2018, the Department of Health and Human Services created a new Conscience and Religious Freedom Division to enforce the rights of doctors and nurses who object to certain procedures on religious grounds. From a legal perspective, this area is constantly evolving and requires institutions and employers to pay particular attention to the changing landscape to ensure compliance. Many practitioners have experienced patients who question their personal religious beliefs.

Disability/Pregnancy

Although the law bans discrimination based on disability or pregnancy, compliance and enforcement can be a struggle, such as the ability to transfer to an examination table. While many institutions have policies and procedures in place for these issues, implementation can be difficult due to lack of funding or staff.

When Discrimination May Be Permissible

It is important to note that not all forms of discrimination are actionable. While state and local laws may differ on each issue (some states prohibit discrimination based on weight or height, for example), several forms of discrimination may be permissible in the context of a practitioner's role as healthcare provider:

Bona Fide Occupational Qualification

A Bona Fide Occupational Qualification is a defense to discrimination in the employment context. It allows employers to set occupational qualifications for employment to a specific job that is "reasonably necessary to the normal operation of the particular business."

In the healthcare context, institutions or employers need to establish proper policies and procedures if they are considering potential discriminatory practices with the basis of a Bona Fide Occupational Qualification defense. For example, some courts have held that gender may be a legitimate Bona Fide Occupational Qualification for accommodating patients' privacy concerns for healthcare professionals who assist with dressing or bathing.

However, courts have found that race is not a relevant factor to consider in addressing privacy concerns.

Political Views/Expressions of Free Speech

The recent advent of social media has made free speech a common topic of debate when it comes to the workplace. Individuals have the ability to post their thoughts and reach a wide audience instantaneously.

Keep in mind that individuals generally do not have freedom of speech rights in the workplace (unless working for the government). The First Amendment applies to government actions, not to the actions of the employer.

Many state and local laws apply to discrimination based on political activities or affiliations, so it is important to analyze these issues. For practitioners, it is important to keep in mind the phrase "the internet is forever." Many practitioners post on social media their thoughts about hot-button issues without thinking through the possible ramifications.

Favoritism/Nepotism

An institution or employer showing favoritism or nepotism in hiring or promotional practices is not inherently actionable or illegal. Individual institutions, however, may have guidelines to prevent such practices.

Comments about work should NEVER be posted on social media. Even inconsequential work topics should be left to private conversation.

Creating a Nondiscriminatory Environment

Practitioners and their employers can take steps to limit or eliminate discrimination so patients can receive quality care and treatment. Promptly recognizing and addressing problem areas is key. Use of policies and procedures, along with their consistent application and enforcement, can help solve problems early.

While most institutions or employers have a workplace discrimination policy for practitioners, some lack a formal policy or procedural process to handle discrimination that originates from a patient. Regardless of who originates the discrimination, it's important to consider its impact on the patient, care, the practitioner and/or other staff, as well as the emotions of those involved.

The *Patient Prejudice* study found that policies and procedures can be lacking. The study specifically found:

- 60 percent of physicians didn't know whether their institution had a formal process for handling patient discrimination.
- 85 percent of physicians said their institution didn't provide training for dealing with bias or they didn't know whether it was provided.
- 16 percent of physicians said their institution had a formal process for reporting patient discrimination.
- 25 percent of physicians who have experienced bias within the past five years documented the incident in a patient's medical record. Only 10 percent of that group said they reported it to an authority. In 20 percent of the cases, the physician was asked to continue caring for the patient after reporting the incident.

Reassigning patients at their request is not always a simple response. Practitioners must consider the Emergency Medical Treatment and Active Labor Act (EMTALA) implications, a law which was developed to ensure treatment to all persons who seek care.

There are numerous other considerations. In fact, "[o]rganizations that make race-based staffing decisions or compel employees to accede to a patient's request for reassignment on the basis of a worker's race or ethnic background may violate Title VII. Nurses and nursing assistants have successfully sued employers who require employees to accommodate such demands by patients."[10]

In *Dealing with Racist Patients*, the authors addressed how to engage a patient who has rejected care due to discrimination against the physician. The authors proposed accommodation, negotiation or persuasion, based on the presentation and evaluation of factors. Most importantly, they note, "the patient's medical condition and the clinical setting should drive decision making."[11]

While many physicians may be independent contractors, they are still often subject to the policies and procedures for the facilities in which they practice. Developing a guideline for handling discrimination among staff and with patients helps limit the stress and emotional toll on those involved. Such situations can lead to staff burnout, as the situations can be mentally and emotionally draining.

Developing a protocol can lead to more predictable, less emotional results. Developing such policies, however, entails a balance of social, professional and ethical concerns.

In *Dealing with Racist Patients*, the authors proposed, "[I]nstitutions should not accommodate patients in stable condition who persist with reassignment requests based on bigotry. Outpatients may be informed that they are free to seek treatment elsewhere if they object on racial grounds to their assigned physician, and inpatients in stable condition can also be assisted in transferring to another hospital."[12] Each institution needs to look to its mission and its patient and staff demographics to develop policies and procedures.

Training and education courses or seminars can assist personnel in handling these matters. This benefits practitioners and the institution and limits the risk of discrimination among employees, independent contractors and patients. Education on how to recognize discriminatory actions, how to react and address them, and how to move forward while continuing to provide quality treatment in a caring environment to all patients should be the long-term goal.

Some of the most dangerous types of discriminatory practices occur when the party discriminated against is in a vulnerable position. This can include minors, employees, trainees, students, interns, residents, and patients who are physically or mentally compromised. The practicing physician must be vigilant in promptly recognizing potentially discriminatory issues, actions and comments.

Risk Management Perspective

Documentation is critical in minimizing potential risk. If a patient makes a discriminatory remark about a practitioner or staff member, it should be noted in the chart in quotation marks without further comment.

Uncommon interactions with and statements made by patients and/or family members should be documented. If possible, those who witnessed the interaction or heard the comments

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should make notes in the medical record. These comments should be placed in quotations. For accuracy's sake, do not hesitate to document even the foulest of language.

Proper documentation can help protect the practitioner in a claim or lawsuit as it serves to establish a version of events. Documentation in the chart should be in addition to any formal reporting or paperwork set forth by the institution.

It is also important to consider the emotional or implicit impact of any discrimination. If the practitioner cannot effectively put the discrimination aside after a negative or repeated patient encounter, he or she should seek assistance to discharge the patient from their care within legal, institutional and policy guidelines.

Certainly, there may be situations, particularly emergent situations, where the practitioner cannot meet his obligation of patient care and must discharge the patient. Use of available resources can be invaluable. Overall, charting and documentation are key in discriminatory situations.

Violence and Harassment Concerns

Any discussion on discrimination in the healthcare environment would not be complete without a specific mention of violence and harassment. These topics are front and center in the media these days.

Employers would be best served to evaluate and develop policies and procedures that work with violence and harassment policies and procedures. "A recent Occupational Safety and Health Administration (OSHA) report on workplace violence in healthcare highlights the magnitude of the problem: while 21 percent of registered nurses and nursing students reported being physically assaulted, over 50 percent were verbally abused (a category that included bullying) in a 12-month period.[13]

It is important for institutions to maintain and update procedures and to continue to educate practitioners, employees and staff.

Institutions may be better able to serve the public, employees, practitioners, patients and their own self-interest by limiting their liability for the actions of others. This can often be done by developing, updating, and adhering to policies and procedures.

Conclusion

Maintaining a nondiscriminatory environment is a common goal because the healthcare setting should be the embodiment of trust, care, privacy and empathy. This goal can be met through education, awareness and processes.

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